NHS Greater Glasgow & Clyde	**Paper No. 20/51**
Meeting:	**Board Meeting**
Date of Meeting:	**27th October 2020**
Purpose of Paper:	**For Noting**
Classification:	**Board Official**
Sponsoring Director:	**Dr Jennifer Armstrong**

Remobilisation Plan – Progress Update

Recommendation

The Board is asked to:

- Note the Remobilisation Plan submitted to the Scottish Government on 31st July 2020.
- Note the progress in remobilising services in the key priority areas.

Purpose of Paper

This paper highlights the progress achieved with remobilisation of health and care services during the COVID-19 pandemic.

Key Issues to be considered

- Current surge of COVID-19 activity
- Priorities for service recovery

Any Patient Safety /Patient Experience Issues

Patient safety is paramount as we remobilise our health and care services. This has driven new ways of working as we maintain social distancing compliance and ensure Personal Protective Equipment requirements are met. A programme of work is ongoing to ensure the patient's voice is heard as we reshape services.

Any Financial Implications from this Paper

Financial implications are described at a high level in the Remobilisation Plan.

Any Staffing Implications from this Paper

Workforce implications are considered throughout the Remobilisation Plan.

Any Equality Implications from this Paper

Equality Impact Assessments will be undertaken as planned services change.

Any Health Inequalities Implications from this Paper

The Remobilisation Plan recognises the significant health inequalities attributed to the pandemic and our societal response.

Has a Risk Assessment been carried out for this issue? If yes, please detail the outcome.

A risk matrix with mitigation has been developed to support remobilisation of services.

Highlight the Corporate Plan priorities to which your paper relates

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Remobilisation Plan – Progress Update
August 2020 – March 2021

NHS Greater Glasgow and Clyde

1. Introduction

NHS Greater Glasgow and Clyde submitted a Remobilisation Plan to the Scottish Government on 31st July 2020 covering the period August 2020 – March 2021. The plan set out our key priorities, building upon the achievements in the first phase of remobilisation. This paper describes the progress achieved to date and the key milestones reached.

2. Background

Remobilisation is monitored weekly at the Strategic Executive Group (SEG) and an activity monitoring template and action tracker is reviewed at the Tactical Groups.

3. Progress Update

The progress to date within each key service area is summarised below.

3.1 Public Health

Our Public Health Team have been key to the recovery and remobilisation process. They have led and supported work around flu vaccination, Test and Protect and support for care homes. In addition, the team is reviewing the Turning the Tide action plan to prioritise where we can have maximum impact and build on changed health behaviours over the COVID period. This includes working with local authority partners to support active travel, target smoking cessation and support weight management services. Key achievements include:

- **Test and Protect**

The Tier 2 Contact tracing service went live in May with capacity now providing a seven day service with 100 people every day. The service is operating with very high demand with peak numbers of 3000 people with a positive test being received in a single week, generating further 8000 contacts to be followed up.

The service is working closely with the National Tier 1 service to ensure monitoring and servicing of demand. Close working with local Councils ensures that local outbreaks are rapidly managed and individuals asked to isolate have the support they require.

- **Support the drive to increase flu vaccination rates among staff and vulnerable groups.**

The Influenza Vaccination Programme commenced at the beginning of October with intention of reaching an estimated 500,000 people across NHSGGC, an increase of over 200,000 people due to the extension of eligibility and expectation of higher levels of uptake.

To support the Adult Vaccination Programme over 30 Community Vaccination Centres have been rapidly established to compensate for the restricted capacity in General Practice. This has involved developments of additional vaccine cold storage capacity at the Louisa Jordan Hospital, establishment of a central booking function dealing with c. 100,000 appointments per month and sourcing qualified staff to deliver vaccinations. Uptake by the end of week 2 (of an 8 week programme) is 22% of the total expected population.

Staff vaccination uptake is progressing successfully with 17% of clinical and 21% on non-clinical NHS staff receiving their vaccination to date.

- **Protecting Care Homes**

A range of support mechanisms were established to the support the 196 care homes during the peak of the pandemic and these included deploying staff, psychological support, training, webinars, provision of guidance and support on a wide range of topics. This support continues as the winter approaches with reruns of training programmes and a focus to ensure sufficient infection control and nursing staff. Cleaning regimes have been reviewed and revised with the adoption of 'treat like hospital' standards. Routine testing has been introduced for staff and residents with the target of 7500 staff tested being achieved. A system of surveillance is in place with daily calls and huddles for all care homes, reporting to the GCC Care Home Assurance Group.

3.2 Planned Care

Remobilising planned care has been challenging as we have maintained red COVID pathways to respond to fluctuating levels of cases, and supported staff who are shielding and who are redeployed to support the COVID response. New infection control and social distancing guidance (including patient testing) has driven the need for new models of care and ways of working. These challenges have driven the pace and scale of recovery.

Achievements in outpatient activity during the first quarter of the recovery period (July-September 2020) include:

- 9421 (9,561) Urgent Suspicion of Cancer referrals received, exceeding the Q1 milestone of 8638 by 9.06%

- 71600 (73,331) new outpatient referrals received, exceeding the Q1 milestone of 64145 by 11.62% (14%)

- 44950 (45,777) new outpatient activity (including virtual appointments by telephone, and NHS Near Me), exceeding the Q1 milestone of 32862 by 36.78% (39.3%)

- Scope activity for Quarter 1 has exceeded the projected milestone of 3572 by 17% (20%).

Delivery of inpatient and day case activity has been supported by a wide range of actions to support the remobilisation process. These include:

- Prioritising cancer care
- Establishing green elective pathways for patients for planned operative care
- Clinically validating waiting lists to ensure priority patients identified
- Re profiling the allocation of theatre capacity to meet priority care requirements
- Increasing day case management of patients
- Using external capacity at GJNH and Louisa Jordan Hospitals
- Improving testing access and increasing pre-operative assessment and pre admission management to avoid patient cancellation

These actions have allowed an increasing recovery programme, with monthly activity growing each month from July – September. The first quarter was below projection but plans are in place to maintain and increase the elective programme towards the winter period.

The following actions have also been noted:-

- Provision of new Virtual Patient Management dashboard to clinical teams
- Implementation of additional Effective and Quality Interventions and Pathways (EQUIP) pathways across NHSGGC
- Home births recommenced in all sectors at the end of July and Community Maternity Units and midwife led birthing options reopened at the end of August

NHSGGC has embraced new ways of working during the pandemic to deliver safe, person centred care. The Orthopaedics Team in the North Sector have progressed plans to deliver hip replacement surgery as a day case procedure at Stobhill Hospital. The aim of the team had been to provide hip and knee replacements as day case for those patients considered suitable. The first hip theatre list ran during w/c 12th October 2020, and the first patient was able to return home the same day with the second patient going home the next morning. The combined effort across the whole of the multidisciplinary team involved has led to this successful new way of delivering hip replacement surgery for our patients, and the learning can now be applied more widely.

3.3 Cancer Waiting Times

All Cancer Multi-Disciplinary Teams (MDTs) have continued to meet throughout the pandemic with most conducting meetings virtually using MS Teams. Since March 2020, MDTs have been applying a prioritisation category to patients with a surgical treatment decision. The MDT co-ordinators enabled the prioritisation category to also be applied to patients retrospectively to ensure the full scale of demand across the Board was identified.

Waiting times for cancer surgery are reviewed weekly and actions to secure dates within the recommended timeframe are agreed. The number of patients waiting longer than their target timeframe has been steadily decreasing as illustrated in Table 1 below.

Table 1

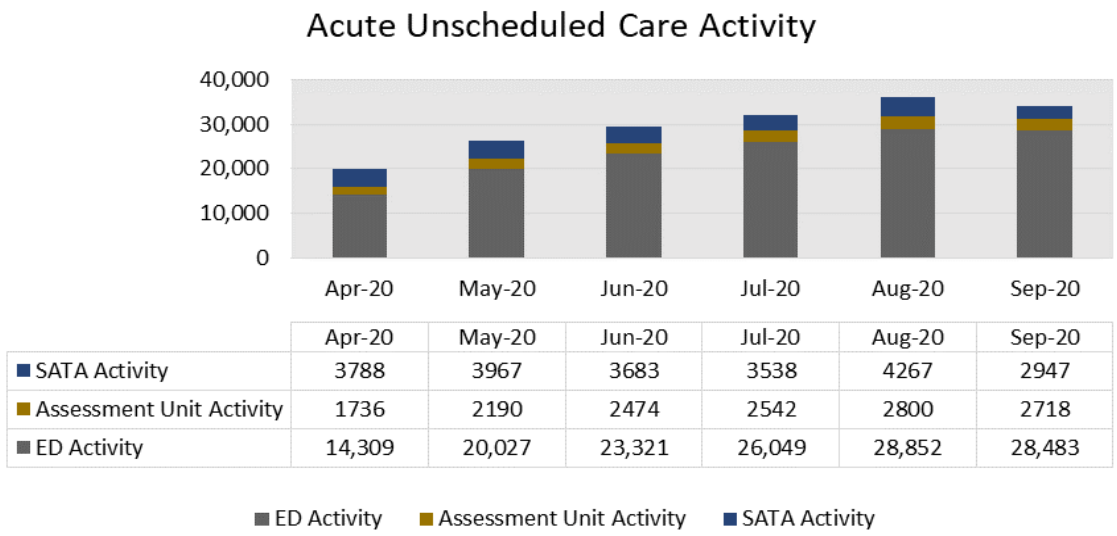
Cancer Type	**Surgery For Booking - Risk Priority Category 2 and 3**		
	18/5/20	**15/6/20**	**5/10/20**
Urology	115	98	20
Breast	56	59	13
Colorectal	26	15	3
Gynaecology	23	21	11

A further achievement has been in the recovery of prostate diagnostics where there has been a significant reduction in waiting times for patients in the South Sector. In April 2020, at the height of the pandemic, approximately 70 patients were waiting for prostate biopsies, some in excess of 4 months. The service was restarted at Gartnavel Day Surgery Unit from May 2020 onwards with assistance from members of the prostate team. Initial retraining and pathways/protocols were put in place for patient and staff safety and have been shared with the Victoria Hospital teams and Radiology to support recovery of their biopsy services. The numbers waiting for biopsies reduced to 3 as of 3rd September 2020, and the waiting time decreased to 2 weeks demonstrating an improved position to pre-COVID. This was achieved as a result of exemplary team work from all the staff at Gartnavel DSU and admin support teams.

3.4 Unscheduled Care

In NHSGGC, we are supporting the national programme to schedule as much urgent care as possible to deliver the right care in the right place. We are progressing the development of new pathways for cohorts of patients whose urgent care needs are best served by services outside Emergency Departments.

As emergency activity has begun to rise from the low levels experienced at the peak of the pandemic in March/April, GGC has been able to consistently meet ED waiting time targets. Our performance has been at or above Scottish average over the summer period. Over the same period and despite a reduction in confirmed cases of COVID-19 over the summer months, activity through the Specialist Assessment and Treatment Centre (SATA) increased as ED activity increased. Assessment Unit activity has also continued to increase.



	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20
SATA Activity	3788	3967	3683	3538	4267	2947
Assessment Unit Activity	1736	2190	2474	2542	2800	2718
ED Activity	14,309	20,027	23,321	26,049	28,852	28,483

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3.5 West of Scotland (WoS) Trauma Network

The Major Trauma Centre (MTC) is due to open in March 2021 with planning well underway to establish the 24 bed major trauma ward which will provide specialist care to major trauma patients and also provide early access to hyper acute rehabilitation.

Progress towards implementation has been achieved in the following areas:-

- A number of pathways have been finalised for access to specialist services including Ortho-plastics, Spinal, Cardiothoracic and Neurosurgery.

- A recruitment plan is being progressed to recruit to the balance of the posts for the MTC – supported by a training and development plan, particularly for the major trauma ward and AHP staff. Key new roles appointed to during the phase 1 planning stage, including Critical Care and Ward Nurse Practitioners, have now completed their two year training courses. Major Trauma Coordinators in the MTC for both adult and Paediatrics have now all been appointed.

- Major Trauma Nurse Educators continue to provide regular training in major trauma competencies across the region to support the upskilling of nursing staff.

- A Clinical Governance Advisory Group now established with representation from each of the Boards across the WoS and the SAS. The group have supported the development of patient pathways and protocols across the system including development of WoS regional repatriation and referral protocols. This includes agreement of SAS repatriation numbers from Major Trauma Centre to Clyde

- The capital plan to support the new services is progressing. This includes upgrades of Ward 22 at RAH and Ward K North at IRH, and a surgical assessment area in Clyde.

3.6 Primary and Community Care

A number of achievements in Primary and Community Care have been progressed. In Pharmacy Services, implementation of 'Pharmacy First' took place in July 2020 across all 219 Community Pharmacies in NHSGGC.

In Primary Care, all GP Practices have remained open throughout the whole pandemic period to maintain services, whilst responding to increased needs of patients as follows:-

- Restart of the cervical screening programme
- Flu vaccination campaign with many practices vaccinating the 18-65 year old patient group and individual practices supporting the wider delivery of the vaccination campaign where accommodation allows
- Increased chronic disease monitoring where appropriate
- Implementation of remote consultation across primary care and community services has been enabled with a mixed delivery of care comprising telephone, 'Face to Face' consultations and NHS Near Me video consultations. Innovative approaches have included the adoption of 'e-Consultations', which enable GPs to consult patients by email
- Consolidation of changes to ways of working is supporting the refocusing of Primary Care Improvement Plans to deliver contract commitments
- GP Practices are observing escalations in demand from patients encompassing a range of issues from minor illness to those which have been postponed by patients during the initial period of the pandemic. A significant increase in patients with anxiety issues has been noted in Practices
- Continuation of a 'senior clinical decision maker' role in the COVID community pathway for both telephone hub and assessment centres by many General Practitioners whilst working in the GP Out of Hours Service.

The service improvements in GP Out of Hours services have underpinned and supported the remobilisation process. Within the new model, all care is scheduled and prioritised based on an assessment of needs. Patients identified by NHS24 as requiring a 4 hour appointment receive an initial telephone consultation with a nurse or GP, reducing the need for many face to face appointments. The new pathways have reduced the need for in person attendances by up to 60%, although calls into the service have remained constant.

Dentists have continued to deliver urgent dental care throughout the pandemic. A return to pre-COVID activity levels is not achievable under the current health protection measures. Remobilisation work is initially focused on delivering treatments to those at greatest risk of oral disease and is being prioritised based on clinical judgement.

3.7 Mental Health

Mental health services have continued to operate throughout the pandemic, ensuring continuous access to emergency and urgent care response. This has largely been made possible by the adaptability and flexibility of staff and adoption of a range of new ways of working including the wide scale roll out of IT and telephone consultation. Face to face

emergency and inpatient care continues to be supported by new working practices, use of appropriate PPE and the adaption of patient pathways.

New Services and Service Delivery Models have been developed in response to the pandemic. Two Mental Health Assessment Units (MHAUs) were quickly established to divert patients away from hospital Emergency Departments. These continue to operate to Standard Operating Procedures in order to reduce footfall through EDs, support Police Scotland and the Scottish Ambulance Service and responding better to patient's needs. Data has shown a reduction in ED attendances, significant uptake by Police Scotland, with positive informal feedback from all stakeholders and service users. A business case has been developed to describe how this model can be made sustainable, locating it firmly within the wider mental health unscheduled care responses.

The broad socioeconomic consequences of the pandemic will have a significant impact on future demands on mental health services and would include social isolation, bereavement and the financial and economic impact of the pandemic. The Board recognises the particular needs and risks experienced by a number of vulnerable groups including people with a Learning Disability, neurodevelopmental disorder, dementia and, severe and enduring mental illness. Evidence is already emerging of a differential impact for people who live in areas of deprivation. For example 20% of the population living in the most deprived areas make up almost 60% of all attendances at the MHAU. The disproportionate impact of COVID-19 on Black, Asian and Minority Ethnic (BAME) groups is recognised, including structural factors operating within the NHS, with a recognised need to work in collaboration with individuals and communities on how best to respond to these needs.

3.8 COVID-19 Pathways

The COVID-19 Community Assessment Centre (CAC) Pathway was developed as part of NHSGGC's response to the COVID-19 pandemic where a 'red' community pathway was established for symptomatic patients. This enabled patients, who were potentially COVID positive, to be cohorted away from General Practice and hospital Emergency Departments. The pathway was integrated into the planned care model for GP Out of Hours, and Community Assessment Centres (CACs), became operational on 23rd March 2020 and continue to operate.

At the peak week of the pandemic, 766 patients attended the CACs. Up to 40% of all onward referrals to the CACs come through the COVID-19 hub with 60+% directed via General Practice.

The pathway has been fundamental in protecting both Primary and Secondary care and will continue to do so over the course of the Winter period. Our staff, including Health Visitors, Physiotherapists, Student Nurses and Health Care Support Workers, were fundamental in the functioning of the Assessment Centres with many stepping out of their normal roles to provide support. The response from staff has been positive, as captured below.

'In Renfrewshire we have mobilised a range of staff to support the COVID response. I am immensely proud and grateful of the number of volunteers who have stepped out of their traditional role to contribute to the COVID response. Overwhelmingly they talk about this being a very positive experience, with feelings of making a valued contribution to a common goal, being part of something bigger, meeting different professionals and disciplines, sharing professional knowledge, learning from each other and building connections. This has to be recognised as an unintentional consequence of mobilising and certainly something as an organisation we should be building on.'

'A staff survey was performed recently. Of those that responded, an overwhelming majority (98%) described their experience working in Barr St. as a very positive atmosphere and

that the teams worked well together with good leadership and approachable staff. They said that it was enjoyable, supportive, enthusiastic, respectful, felt engaged and involved. Working with a skilled bunch of people with positive attitudes and forward thinking staff means that staff are proud to work there. Some comment on this as the best experience they have had in the NHS. The majority (88%) commented that information was given and received well using a range of methods, updates in team meetings/huddles. All views were heard and management presence was useful for guidance. Most felt that there was a safe and smooth patient journey that it was person-centred with effective management and systems were in place to support safety. Patients are treated with empathy and no long waiting times with patient outcomes i.e. going to hospital or home.'

'Fantastic collaborative environment, real camaraderie, best working environment I have been in for years.'

'Throughout my whole time I felt the teamwork within both the clinical corridor and the testing team was wonderful. Such a lovely and wonderfully skilled bunch of people who gelled incredibly well under the pressure of a worldwide pandemic.'

'We had 600 individual comments from staff and they're really, really, really positive. 96% of the respondents or the staff who responded said that they felt team working was effective at this centre. 94% felt that their wellbeing was supported. 92% felt they were listened to. 88% felt they were informed about the service and where it was going. And 85% felt that they could provide feedback, and that feedback was listened to, so really, really positive results.

3.9 Workforce

The remobilisation plan recognised culture, collective leadership and most importantly staff health and wellbeing, as key priorities in supporting our workforce moving forward. The following actions have since been achieved:-

- Approval of Mental Health and Wellbeing Action Plan and establishment of a working group to deliver in support of our focus on staff mental health and wellbeing. This includes creating a sustainable model for the Rest and Recuperation Hubs in both Acute and Mental Health. A Psychological Mental Health Check-in was developed in-house. From 31st August until 29th September, 1094 staff have responded with 441 having dedicated support and signposting to services with the survey to be repeated in 3 months' time. Peer support for clinical staff models being finalised and support to leaders including coaching. Additional resources to Occupational Health including psychology and CBT support being recruited.
- Issue of annual leave reports, including comparative year information, to sectors and directorates to enable workforce planning arrangements and ensure staff are taking appropriate breaks along with daily Covid-19 absence activity.
- Development of an enhanced 'Return to Work' process to specifically support staff who have been shielding and those with carer responsibilities. This included a detailed risk assessment approach which is revisited with individuals depending on needs.
- Completion of over 1286 site and area risk assessments to identify requirements for additional social distancing measures implemented through Estates and Facilities with Health and Safety focussed Social Distancing Guidance developed in partnership. A working group to look at risk areas and behaviours to ensure on-going communication and engagement with staff in order to maintain social distancing requirements.
- Significant recruitment to support Test and Protect.

Since March 2020, the Organisational Development Team (Acute and Corporate) supported by staff reassigned from a range of departments including Health Improvement, Health & Safety and Chaplaincy worked together to deliver Staff Rest & Recuperation (R&R) Hubs across the Acute Sector. The hubs are

designed to support staff wellbeing throughout the COVID-19 pandemic and our staff have since responded positively to the support available. Data gathered from a structured staff survey undertaken in June 2020 highlighted the following:-

- 88% of 706 respondents had visited their local R&R Hub
- 87% of 615 respondents considered the pleasant environment to be the most enjoyable feature
- 87% of 696 respondents confirmed their awareness of psychological help and support from NHSGGC.

General feedback from the survey has been encouraging with staff noting the hubs provided a *'positive and uplifting atmosphere'; 'able to develop relationships with Chaplains and resources they can provide including non-religious support'; 'walking to the hubs was good for wellbeing with fresh air to clear head and leave work'; 'nice to feel valued'; and 'a feeling of being recognised and invested in by our employers*.'

3.10 Digital and Innovation

To support delivery of more virtual outpatient consultations across Acute, Mental Health, Community and Primary Care Services, the following has been completed:-

- Reconciliation of the patient information system, 'Trakcare' with 'Attend Anywhere' appointments
- Completion of Equality Impact Assessment (EQIA) for Active Clinical Referral Triage (ACRT) and Virtual Patient Management
- Implementation of live dashboards to provide reporting framework for Acute, HSCPs, and Community Services
- Establishment of governance structures within HSCPs, and Acute Service Outpatients, to support implementation

The number of referrals vetted through Active Clinical Referral Triage (ACRT) has almost doubled for June 20 (6.8%) to August 20 (13.3%). In mental health, face to face consultations have reduced from (92.1 %) to (67.72%) in the last 12 months, reflecting increases in telephone, virtual and written consultations.

Patient evaluation of Near Me has been completed by the Patient Experience Public Involvement (PEPI) Team with 83% of those who responded reporting that they found Near Me technology easy to use. It was also evident that the Near Me system has proven to be a valuable tool during COVID-19 as it enabled patients to have safe access to care and treatment. A detailed report of this evaluation will be presented to the Corporate Management Team and the appropriate governance committee in due course.

The Near Me evaluation was part of a wider programme of stakeholder engagement being led by the PEPI Team to evaluate new ways of working to support the remobilisation of services.

4 Conclusions

A significant number of milestones have been achieved in the key service priority areas to date. Action is being taken to mitigate the risks and challenges presented in other areas, and regular review at (SEG) will take place.

The tracker, supported by the Activity Monitoring Template, will enable visibility of all re-mobilisation actions and the ability to track collective and individual progress.

5 Financial Impact

The estimated costs of Remobilisation of c£28.4m were submitted to the Scottish Government in September 2020 as part of the Quarter 1 Covid-19 return. The Board Finance Paper details the response and funding allocation received to date and the on-going discussions with Scottish Government.

6 Recommendation

The Board are asked to note the progress achieved to date in remobilising health and care services.

DRAFT
Remobilisation Plan

NHS Greater Glasgow and Clyde

August 2020 – March 2021

Contents

Executive Summary: GGC Next Phase Draft Mobilisation Plan

Current position:

Over 160 people with COVID-19 are currently being treated in NHS GGC hospitals. This has reduced significantly from the peak of 600 patients in April, but still presents a challenge for acute hospitals maintaining red and green pathways. Emergency activity is beginning to rise to around 70% of pre COVID-19 levels, after a drop in April to less than half the level in previous years. Reduced capacity, infection control demands and staff availability have resulted in elective activity being focussed on urgent cases and cancer care. HSCPs and primary care services have continued to provide urgent and emergency care throughout the pandemic period, and are now looking to resume routine and preventative services. To inform the planning process, we have revisited our winter planning arrangements and have modelled a possible second wave of COVID-19.

Approach:

This plan has been produced collaboratively across the system of health and care in GGC. Our shared principles noted in the plan have provided a framework to base remobilisation on, and the Recovery Tactical Group have led the process. The plan has been developed in partnership with staff representatives at each level of planning, and our comprehensive engagement process has included an interactive session with public representatives. This session was attended by 20 third sector and public representatives who gave positive views on the new ways of working (including NHS Near Me and Mental Health Assessment Units) and suggestions for communication about remobilising services.

The key areas which are described in each section of this plan are summarised below.

Key Priorities:

1. Public Health

    - Review our Turning the Tide action plan to prioritise where we can have maximum impact and build on changed health behaviours over the COVID-19 period.
    - Work with local Councils and other partners to support active travel, target smoking cessation services and support weight management initiatives.
    - Monitor the daily totals and clusters of cases to ensure rapid effective management of local outbreaks.
    - Maintain a tier 2 contact tracing service to address complex tracing and local outbreaks.
    - Work with partners across GGC to mitigate the health inequalities impact of COVID-19 and our societal response.
    - Support the drive to increase flu vaccination rates among staff and vulnerable groups.
    - Work with Public health and HSCP colleagues to support care home staff to protect residents, focussing on clear advice, testing, access to PPE and training

2. Planned Care
   - Increasing outpatient capacity to 80% of 2019/20 rates by December 2020 by expanding use of virtual patient management, extending the EQUIP programme, clinical validation and reprioritisation of waiting lists and using group management of patients as appropriate
   - Increasing endoscopy capacity by reviewing site arrangements, enhancing staffing and using external capacity
   - Increasing radiology activity by recruiting 35 replacement radiography staff, and modelling scenarios with differing levels of input and resource to address the backlog
   - Prioritising treatment of all category 3 cancer surgical patients, particularly targeting the urology tumour group
   - Increasing inpatient capacity by clinically validating waiting lists, increasing day management of patients, enhancing staffing arrangements, enhancing pre-op assessment and pre-admission management, running additional sessions and utilising external capacity. It is planned to increase to 60% of 2019/20 rates by October 2020.
   - Recommencing of the full home birth service in all areas by the end of July 2020 and reopening of all Community Midwifery Units by end of August 2020
   - Maintaining surge capacity in adults and paediatrics to cope with COVID-19 spikes and winter

3. Unscheduled Care

   - Supporting GPs by offering a consistent range of electronic advice options as an alternative to admission to Assessment Units
   - Maintaining COVID-19 pathways in hospitals and communities to protect staff and patients
   - Continuing the service improvements to the GP out of hours service
   - Ongoing support for successful service changes implemented during COVID-19 e.g. signposting at EDs, SATAs and Community Assessment Centres
   - Developing the GGC response to the national work to increase scheduling of urgent care including flow centres
   - Implementing the West of Scotland trauma network, including the establishment of the Major Trauma Centre at the QEUH

4. Mental Health

   - supporting the public mental health response to expected increases in demand for mental health support following COVID-19 and the economic disruption
   - developing the digital mental health response, recognising the specific needs of some care groups
   - consolidating the unscheduled care response to mental health and addictions needs, building on the Mental Health Assessment Unit model established during the pandemic
   - addressing waiting list challenges for CAMHS and psychological therapies

- engaging with the Third Sector and other stakeholders as key partners in the remobilisation of mental health services

5. Primary and Community Care

- Supporting primary care and community services to take advantage of remote consultation
- Refocusing Primary Care Improvement Plans to deliver contract commitments and support recovery in GP practices including Chronic Disease management
- re-establishing buildings based day care and respite services
- recovering care at home services across GGC with consistent eligibility and access criteria
- scaling up activity in MSK physiotherapy and podiatry
- responding to increasing demand for rehabilitation services, particularly for patients recovering from COVID-19
- implementing Pharmacy First in July 2020 across all 219 community Pharmacies in GGC
- supporting patients post COVID-19 with a comprehensive rehabilitation package
- Remobilising dental services across GGC
- Developing a robust rehabilitation service for COVID-19 patients

Enablers:

1. Workforce

- Staff mental health and wellbeing is a key priority for the next 18 months with a focus on delivering our Mental Health and Wellbeing Action Plan.
- Workforce planning will be key to maintain the level of services required including ensuring appropriate steps are in place to encourage and support to take annual leave.
- We will be maintaining the skills learned during the peak to ensure we can reallocate staff at short notice should a further peak of activity occur
- Shielding staff and those with carer responsibilities will be supported back to work through an enhanced return to work process
- Maintaining appropriate social distancing is important for the safety of everyone.

2. Digital and innovation

- delivering more outpatient consultations virtually, across acute, mental health, community and primary care services
- scaling up the learning from our innovations projects supporting remote management of patients

3. Infection Control

- All sites have maintained red and green pathways for emergency patients
- Physical distancing guidance has been produced to provide advice for staff

- To support staff health and well-being, advice is available on the Board's website

4. Finance

- Additional public health costs are highlighted for Test and Protect, flu vaccination programme and BBV testing
- Investment in planned care capacity will be required to treat the backlog and address waiting lists
- Ongoing COVID-19 costs will be incurred while the red and green pathways remain
- Winter costs have been identified as similar to previous years

1. Introduction

1.1. *Background*

This is the draft Remobilisation Plan for NHSGGC covering the initial period from August 2020 to March 2021. It builds on our previous Remobilisation Plan which covered the period to the end of July 2020, and focuses on safety, delivery and financial sustainability. The plan has been developed in partnership with stakeholders across the health and care system and has been informed by clinical prioritisation of services and national policy / guidance framework. The Scottish Government document entitled "*Responding to the Re-mobilisation, Recover and Re-design Framework*" sets out 3 core task which include:

1. Delivering as many normal services as possible, as safely as possible
2. Creating and protecting the capacity to deal with the continuous presence of COVID-19, and
3. Preparing health and care services for winter

This plan describes how NHS GGC will deliver against each of these priorities.

Our plan sets out how we will manage the backlog of Planned Care and support Community and Primary Care Services to manage unmet demand, whilst also managing demand for Unscheduled Care. This has driven our whole system approach, focusing on transformation and redesign. NHS Greater Glasgow & Clyde recognises the importance of a Public Health approach and has identified the following priorities.

- Responding to COVID-19 in the context of influenza and healthcare pressures associated with winter
- Re-mobilising services in a safe efficient way that takes into account the needs of vulnerable groups
- Strengthening our multi-agency response to health inequalities, acknowledging the worsening of these inequalities due to the pandemic and its consequences
- A major shift to prevention through re-mobilisation of health improvement services, strengthening of the Health Promoting Health Service model and building the health behaviour changes of lockdown to maximise impact.

1.2. *Key Principles*

The overriding principle which must guide recovery planning is the need to provide safe and effective services for patients which maximise the health benefits for our population. The Strategic Executive Group (SEG) approved the principles below to support this:

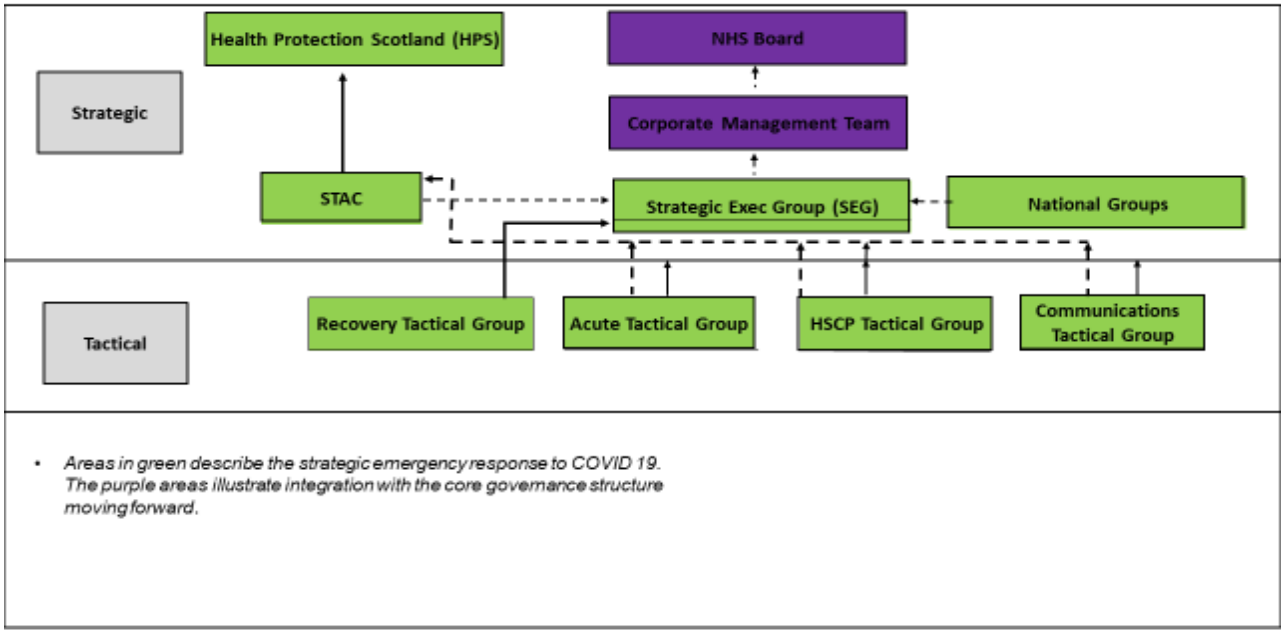
Recovery must be flexible to respond to future potential COVID waves	Senior decision makers will triage patient management on agreed system-wide thresholds and criteria for care	Social distancing will shape the way we deliver services in the future
Patient and staff safety is paramount (testing and isolating as necessary)	Recovery planning will take an inequalities sensitive approach, recognising the impact of societal changes by the COVID response	We will embrace new ways of working
We will continue the cross system working, which has been successful in the COVID response	We must maximise the opportunities of using digital tools to enable and sustain recovery	Supporting staff health and wellbeing is critical

1.3. *Governance*

NHSGGC adopted interim governance arrangements during the COVID-19 pandemic which provided the flexibility required to ensure appropriate governance and oversight, ensure the Board's senior leadership to dedicate the required time to respond to the pandemic, and protect the health and ensure the wellbeing of all those engaged in delivering care and services across GGC. The Scottish Government were aware of the approach adopted. As we have moved into the remobilisation phase, these arrangements were reviewed by the full NHS Board at the end of June. The Board is now in the process of restarting the core governance structure. There are many benefits from the response adopted through the emergency response period in terms of swift decision making and integrated working. However moving forward, it is important that this is appropriately integrated with the core governance structure and this will remain under review over the coming weeks and months.

The cross-system approach to tackling the emergency response to COVID-19 will continue to support recovery moving forward, recognising the interdependencies between the component parts of our health and care system. A Recovery Tactical Group has now been established to work with the Acute and HSCP Tactical Groups, and reports to the Strategic Executive Group and now onward to the CMT and the Board and subcommittee structure as appropriate. The approach is detailed in the diagram below.

COVID-19 GOVERNANCE STRUCTURE



The Recovery Tactical Group is supported by a group of clinical advisors which includes representatives from the medical, nursing and the allied health professions. NHSGGC's Re-mobilisation plans have been developed via the governance structures implemented during COVID-19. Both the Acute and HCSP Tactical Groups include clinical leadership and there is a separate primary care group with wider clinical engagement of primary care clinicians and the Local Medical Committee. Changes in pathways or referral criteria have been developed jointly prior to agreement at the Strategic Executive Group. A register of all changes has been kept so they can all be reviewed as part of recovery and joint agreement reached on the way forward. The Primary care Lead Clinician for Cancer, who is a GP, has been involved in changes to cancer pathways.

NHSGGC has well established interface arrangements including a longstanding Primary/Secondary Interface group including the Depute Medical Directors for acute and primary care, GP Sub Committee, COO acute and HSCP Chief Officer. In addition there are a number of joint planning and governance groups including Managed Clinical Networks and the Referral Management Group.

1.4. *Engagement*

Key stakeholder engagement has been fundamental in the COVID-19 response and remobilisation planning in NHSGGC. The Recovery, Acute and HSCP Tactical Groups have worked jointly with key stakeholders to develop and agree changes to pathways and referral criteria, and this cross system collaborative approach has now evolved to support the recovery planning and remobilisation of services across NHSGGC.

Staff Engagement
Throughout the COVID-19 pandemic the Board has engaged fully on a weekly basis with its Area Partnership Forum, which is jointly chaired by the Employee Director and the Director of Human Resources. The Forum members have discussed Personal Protective Equipment (PPE), Staff Testing, Shielding, Mental Health and Wellbeing support to all staff and are now developing and implementing actions with Human Resources on Recovery and Reconfiguration for both workforce and workplace. This includes continued mental health and wellbeing support, workforce supply and planning, workforce redesign elements

to the mobility plans, social distancing, homeworking, contact tracing and the development of local guidance and support relating to all these areas through relevant working groups. The Employee Director is a member of the Strategic Executive Group and Recovery Tactical Group. The Co-Chair of the Acute Partnership Forum is a member of the Acute Tactical Group and the staff side co-chairs are members of the HSCP Recovery Plan groups.

In responding to the pandemic, Forum members have been proactive in bringing forward issues and ideas to support the Board's decision-making, and this has continued to support a positive and productive recovery.

The Board's Scientific and Technical Advisory Group has produced guiding principles to ensure that the reintroduction of services is in line with current evidence and infection prevention and control requirements. All plans to restart services within the acute division are considered by the Acute Tactical Group and must include an estimate of the impact on Level 2/3 care and PPE and take into account the updates given by pharmacy on medicines supply. In addition, there has been significant work to ensure infection control issues (including PPE) are clearly set out and delivered within HSCP services.

Directorates within NHS Greater Glasgow and Clyde were given debrief templates to record their learning experiences during COVID-19. Noted below is a summary of the key recurring themes and practices identified:

- Daily Corporate Communications and Briefs – precise and informative keeping staff up to date on new guidance and keeping staff connected.
- The rapid and widespread implementation of NHS Near Me, enabled patients to be prioritised and be provided with clinical consultations where necessary;
- Reassignment and recruitment of staff, building capacity and resource across the Board and the Staff Bank Service
- Improved collaborative working across teams and Directorates allowing for problem solving and cohesiveness to development new processes and systems.
- Early implementation of "Command and Control processes
- Staff flexibility and a sense of pulling together with a strong team ethic

Public, Patient and Staff Information

Staff engagement has been further supported through strong internal communication with staff about delivery and service changes. This has included daily Core Briefs to communicate core messages to staff whilst also encouraging feedback. Operational and clinical teams, Managed Clinical Networks and Primary/Secondary Care interface groups, and clinical specialities have provided direct input into the recovery planning process, sharing positive responses to changes made to services, as well as to clinical priorities for recovery and remobilisation.

A standard remobilisation presentation has been developed to be used widely across GGC and with a wide range of stakeholders to ensure consistency in the communication delivered. It has been delivered to as many routine/established meetings and forums as possible as well as a Board Seminar and with the Public Stakeholder Reference Group.

This collaborative joined up approach has ensured consistency in meeting the needs of the recovery and mobilisation planning process, ensuring effective 2 way communication

across new and existing structures which has influenced and shaped changes across NHSGGC.

It is envisaged that this structured approach will continue to operate during the remobilisation period alongside the re-establishing of standard governance structures, and will be key to identify and address emerging issues and influence our thinking and decision making, as we continue to stand up services and implement improved pathways and new ways of working.

Patient Views on Service Change

To further support engagement in the planning processes outlined above, a fundamental part of the Remobilisation work will be to engage with our key stakeholders to change how we deliver care in the future and gather the experiences of our patients, carers and families to test and coproduce new ways of working. In developing the Remobilisation Plan early and ongoing engagement with NHSGGC's Stakeholder Reference Group, drawing on their experiences is key to ensuring the public voice is present from inception and through implementation of the plan.

A special meeting of the Stakeholders' Reference Group was convened to engage with members about the recovery of services, and the Remobilisation Plan. Members of the public and Third Sector representatives from across the NHSGGC area attended a Teams meeting on 27th July. They received a presentation on the key elements of the Plan, and there was opportunity for them to ask questions and raise issues. Main points raised were:

- Phone calls - patients need to understand why they are being called and who they are speaking to
- Mental Health Hubs – very good and work well
- Near Me – not for everyone and patients should have a choice, but several examples of positive experiences of virtual appointments. Request for more information to patients on the new digital systems for reassurance
- Young patient attending for a paediatric cardiology appointment – staff clearly explained the system for social distancing and parents reassured.
- Concern about staff welfare following the pandemic peak – members wanted to know how we are looking after the emotional health of staff
- Primary Care – general support for telephone and video appointments
- Communication - Need to ask patients what the preferred method of communication with them should be – email/letter/text
- Communications and Engagement Strategy (planned for autumn 2020)– support for a strategy, and interest in influencing it

We have made a commitment to follow up on these points raised.

As part of our initial engagement the Patient Experience Public Involvement (PEPI) Team are also delivering on a programme of stakeholder engagement to evaluate new ways of working that have been implemented in response to the COVID-19 pandemic. These were commissioned by the Recovery Tactical Group, with the PEPI Team gathering the views and experiences of patients and staff in relation to the following remobilisation work streams:

- Signposting pathways for unscheduled care within community and acute services
- Use of Virtual Consultations and Near Me

- GP Out Of Hours – use of the appointment system and Near Me

As part of the stakeholder engagement work, the PEPI Team will work closely with the Equality and Human Rights Team to ensure our engagement approaches are accessible and support us to reach our diverse patient groups. In addition, the Equality and Human Rights Team will also carry out discrete pieces of engagement to capture the views and experiences of protected characteristic groups who have recently used Near Me including patients whose first language isn't English.

Taking into account social distancing measures, the PEPI Team are utilising a variety of tools and techniques, taking a remote and digital first approach to engagement. PEPI will focus on the use of social media, virtual discussion sessions and remote interviews to capture stakeholder views and experiences as well as explore further approaches in line with social distancing measures.

NHSGGC will remain committed to listening and learning from the views and experiences of our staff and patients and other key stakeholders throughout remobilisation, and will draw on them to influence how we shape and embed new models of care, ensuring a person-centred approach to how we design and deliver services.

1.5. *West of Scotland Regional Working*

The West of Scotland Boards under the Mutual Aid agreement have considered and agreed a regional approach to a number of areas outlined below. The regional response is in line with the planning assumptions set out by Scottish Government to optimise what we can do collectively in these challenging times. Appendix 3 describes in detail how the West of Scotland Boards will work together during remobilisation.

1.6. *Risk*

As the Board progresses with recovery planning, we are starting to capture information on circumstances which may adversely affect our ability to implement prioritised mobilisation. On this basis, a risk register will be maintained to provide a mechanism to evaluate risks and plan for additional actions to mitigate such risks. The key risks currently identified, and mitigation are set out below:-

Risk Description	Mitigation
There is a risk that a 2nd wave of COVID-19, whether manifested as a general increase across the population or as multiple localized clusters, will lead to significant delays to patient treatment for emergency, cancer and planned care. This risk is heightened over the winter period when demand for unscheduled care will be higher.	Flexible, and new ways of working to continue to treat patients. Continue to use dedicated pathways for emergency patients. Continue to work in partnership with HSCPs to reduce delayed discharges in Acute Services. Ongoing treatment of clinically urgent cases On-going support of independent sector and GJNH. Flexible deployment of Test & Protect and Health Protection Team resources to rapidly respond to clusters and outbreaks
There is a risk that staff absence due to backlog / annual leave /shielding/sickness will lead to impact on delivery of patient care.	Continued monitoring of staff absence on SSTS; Ensure ease of access to guidance and support to staff regarding testing; health and wellbeing support; reassignment of staff in non-essential roles in line with agreed partnership approach.
There is a risk that 'New Ways of Working' will lead to increased costs.	All Sectors/Directorates have established tracking processes. Significant additional expenditure was described in the initial mobilisation plan, and decisions recorded at local level and escalated where appropriate for approval.
There is a risk that the ongoing measures to support the response to COVID-19 will reduce capacity across specialties and increase waiting times for inpatient and outpatient appointments.	New ways of working to continue to treat patients optimally. Development of recovery plans; Support of independent sector and GJNH.
There is a risk of widening health inequalities as a consequence of the pandemic.	Planning for the short, medium and long-term societal impacts and developing evidence based responses to increased poverty and health inequalities; collaboration with the voluntary sector to reach the most vulnerable groups; and monitoring impact in the population and in population sub-groups.
There is a risk that an EU exit without a deal will lead to medicines shortages	Ongoing work with the department of Health and Social Care and the pharmaceutical industry to ensure sufficient stocks are in place to provide a buffer for customs / border delays. Overseen by representatives of the Scottish Government Medicines Shortages Response Group

1.7. *Clinical Engagement*

To provide early structure to the recovery process, NHSGGC has undertaken an exercise with all clinical specialties across the Acute Division and HSCP services to capture the important positive changes made during the COVID-19 emergency footing and the main priorities for recovery.

The process to capture this information has utilised the active clinical engagement and effective team working within and across Sectors/Directorates that has been a strong feature of the COVID-19 response in NHSGGC. Specialty teams from across GGC have come together to set out their GGC-wide specialty response focusing on harnessing and expanding the digital approach to recovery and agreeing priorities for how services move forwards. This is all set in the context of maintaining flexibility to respond to any future surges in COVID-19 patient admissions. All services have made significant changes during the COVID-19 response, learning throughout this period. The experience gained means services will be better placed to continue a wider range of service delivery during any further COVID-19 surge.

The output from these recovery templates was collated into a report and informed collective action across NHSGGC. This included a drive to adopt rigorous monitoring of digital activity, a principle of digital first wherever possible for patient interactions and further work to ensure patients who do not have, or are unable to use, digital access are not disadvantaged.

Key Points
• **Our re-mobilisation has a strong focus on health improvement and preventing ill health** • **The principles underpinning our plan seek to support safe and effective services for patients and staff** • **We have taken a system wide approach to recovery, involving staff partnership** • **Clinical engagement has been a strong feature of our remobilisation planning** • **We have agreed a regional approach to mutual aid, working with other West of Scotland Boards**

2. Public Health: Poverty and Health Inequalities

2.1. *The Journey to July 2020*

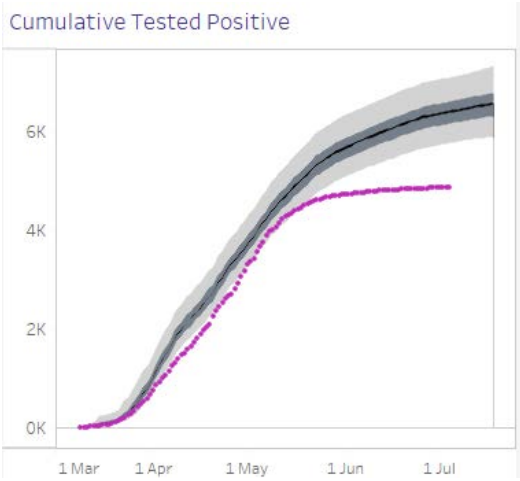
Our priorities identified for the period up to the end of July were:

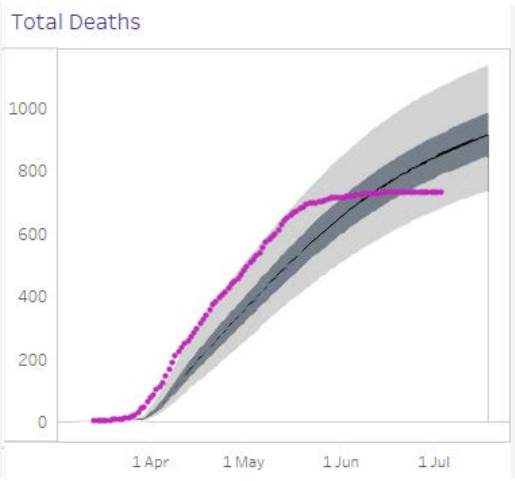
- The challenges to inequalities caused by COVID-19 and our national response to the pandemic
- Maintaining the vaccination programme
- Working with the 196 care homes in NHSGGC to protect residents and support staff
- Implementation of the Test and Protect programme by the 1st June
- Prioritisation of patients identified prior to the halting of the screening programme within our clinical services work

As we move from the immediate responses to the COVID-19 pandemic, our attention for the 2nd half of the year needs to focus on implementation of Test and Protect as well as restarting and strengthening our work on health improvement and addressing health inequalities. These latter areas of work will be underpinned by population and area-based data on need and the impact of the pandemic by area and vulnerable groups.

The impact of the virus extenuates many of the themes within the Boards Public Health strategy "Turning the Tide through prevention". Our response will require specific elements to go further faster. The Public Health Directorate will still be dealing with the pandemic especially in relation to Test and Protect, outbreak management and vaccination. There will therefore be a review of the action plan attached to "Turning the Tide through Prevention" to prioritise areas of work likely to have maximum impact over this period.

The charts below describe the cumulative position of people testing positive and the deaths attributed to COVID-19. Whilst actual figures fell below the projections, the number of recorded deaths by early July was 732.





Source: Public Health Scotland: Short Term SEIRs Forecast Model (Purple line – actual figures)

SEIRs relate to a patient being susceptible (S), exposed (E), infected (I) and recovered (R).

2.2. *The Challenge to March 21*

There is a high degree of uncertainty in how the COVID-19 epidemic in NHSGGC will evolve over the winter months of 20/21. However, the Academy of Medical Sciences (AofMS) document Preparing for a Challenging Winter 2020/21 suggest that if the R0 (basic reproductive number based on number of secondary cases from a single case) remains low (R0 1.1), then there is unlikely to be an obvious second peak over the winter months. Therefore, in this model COVID-19 would have minimal impact on health service demand, over and above our typical winter demand.

If from September 2020 the R0 increases to 1.5, they estimate a second peak of COVID-19 cases, admissions (including ICU), and deaths occurring in January /February 2021. The median of this peak is estimated to be ~2/3 the size of the first peak experienced in April / May 2020. However, if R0 increases to 1.7 from September 2020, infection would be expected to rise gradually over the autumn and winter months with a peak in hospital admissions and deaths of a similar magnitude to the first wave, again in January / February 2021.

The AofMS modelling assumes a number of things: that transmissions will follow a similar pattern to the first wave, that the estimated R0 in September 2020 remains the same throughout the time period being modelled, and that COVID-19 transmission will be influenced by similar climatic conditions as other respiratory tract infections.

However, not included and less certain, is the potential impact of local outbreaks, the degree to which immunity is conferred by past infection, potential interactions between other respiratory viruses and COVID-19, mutational change of the virus, level of adherence to population based mitigations, adverse impact of lockdown on general health, and the pattern of transmission in particular groups and settings. Experience nationally and locally since the launch of Test & Protect, is that management of cases, clusters and outbreaks is the norm, and a generalised increase in community transmission has not yet been seen.

The Public Health Directorate has reviewed its staffing and resources in Health Protection to ensure we have the flexibility to deploy staff to support outbreak management as required. The additional resources requested below include staff to support local management of outbreaks. Our local guidance has been updated and a multi-agency exercise on multiple COVID-19 outbreaks has been undertaken. Work with Environmental Health is on-going to support local businesses and factories and with education colleagues to facilitate communication and support actions should local outbreaks occur. We anticipate the publication of the national outbreak workbook and sector specific action cards to further strengthen our pre-planning and response work.

2.3. *Test & Protect*

Testing of symptomatic members of the general public will take place mainly through the Glasgow Airport testing centre, mobile units or home test kits within the UKG testing

programme using the Lighthouse Laboratory. Weekly testing of care home staff comes through the social care portal of the same programme. From July 2020, symptomatic health and social care staff will also use the UKG programme although NHS GGC will re-open our drive-through and clinic centres for staff testing if numbers increase again. Testing as part of outbreak management and care home resident testing will be undertaken through a variety of routes including mobile testing teams, the HSCP centralised testing hub and primary care and community staff but all will be through the NHS Lab.

Our Contact Tracing successfully launched at the end of May with a workforce drawn from initially reassigned staff and now utilising staff who are shielding. It is a fluid workforce as a consequence of staff returning to their primary roles but we are building resilience by development of a staff bank and a 'reservist' cohort of staff who may be called upon in response to increased demand.

Throughout this period we have worked closely with NSS and PHS to support development of the digital contact management platforms and planning of the National Service. As of the 13th July, NHS GGC have commenced the transition process to the national Tier 1 service.

We will maintain a core Tier 2 service to address complex tracing and local outbreaks. We anticipate that this will continue to manage the bulk of contact tracing within the NHS GGC area assuming current levels of contagion are maintained.

General health protection work will increase due to coming out of lockdown. A resurgence of communicable disease activity for the health protection team e.g. Norovirus, GI infection or environmental health issues will be managed by the health protection team. Working with local Environmental Health colleagues and utilising the strengthened staffing detailed below, we would be in a position to manage routine Health Protection work, in addition to two simultaneous large outbreaks, and have recently conducted a multi-agency exercise for this scenario. We have well developed links with Local and Regional Resilience Partnerships and mutual aid arrangements with neighbouring Boards.

Planning has commenced with the West of Scotland Public Health Network to update the Memorandum of Understanding on Mutual Aid and to ensure that there are systems in place to support mutual aid and to agree priorities amongst Directors of Public Health. The additional health protection staff proposed in the section on resources and deployment of consultants in public health into health protection will support the health protection team as required. There are arrangements already in place based on experience over the last 4 months.

2.4. Inequality, Poverty & Mental Health

NHSGGC has some of the highest levels of deprivation and poverty within the UK. Issues of inequality and exclusion are at expected to be heightened as a consequence of the lockdown period and the very real risk of increased unemployment that results from it.

Poverty increases the higher risk of illness and premature mortality through factors which are related to unhealthy behaviours characterised by limited school attendance and educational attainment, limited job opportunities and unemployment, higher rates of smoking, consumption of harmful levels of alcohol, poor diet and limited physical activity. As we plan the resumption of our health services, we need to take into account these social factors as they will impact on how people use them. There are concerns that capacity within the third sector may be challenged as a consequence of the pandemic and that organisations that previously worked to mitigate issues and provide a safety net may no longer be in place to support the complex needs of our deprived communities.

At the same time there have been early signs of some population level behaviour changes that ideally could be sustained and increased as lockdown restrictions are lifted. These include active travel, smoking cessation and weight management which will become priorities for the revised work plan of “Turning the Tide through Prevention”.

Over the next six months, existing strategies to mitigate child and family poverty such as “Healthier Wealthier Children”, Long Term Conditions Financial Inclusion, and HSCP Local Outcome Improvement Plans will be revitalised.

Plans have been developed to facilitate return of Money and Debt advice services to face to face delivery in acute settings as and when it is safe to do so, ensuring adherence to social distancing measures and required ways of working. We continue to work with Money and Debt Advice services to ensure that patients or families referred are supported promptly by telephone, e-mail or video call and going forwards will continue to seek to reduce barriers to service access.

Local Child Poverty Action and Reports – HSCPs have delivered support directly to families in particular via Humanitarian hubs providing access to food, vouchers or BACS payments to families eligible for free school meals, support with heating/ energy issues and access to Money and Debt Advice services.

Mental health issues have emerged as major population challenges as a result of the COVID-19 pandemic (as evidenced by multiple tracking studies) and require a comprehensive response both at Board and HSCP level. A significant section on public mental health development and investment is included in the GGC NHS Mental Health Reablement Plan and sections of this plan. They will be taken forwards in partnership with wider community planning partners.

Tracking and needs assessment work highlights that there are major, evolving needs for the GGC population in the areas of alcohol and drugs. The Board will connect closely with each of the ADPs to ensure a comprehensive public health approach to these areas, which connects closely to a range of other planning themes, including mental health, social recovery, anti-poverty and clinical service reablement.

NHSGGC has been a leading participant in the National Specialist Interest Group working on Public Mental Health. The draft recommendations highlight the importance of the mental health dimensions of the COVID-19 pandemic, building leadership in ensuring that they feature prominently in national and local “recovery planning”, and building on emerging evidence of current and anticipated need. We will require a cross system approach to build the capacity to support well-being through active connection and joint working with the other public health priority areas (ensuring mental health is prominent in

child and youth public health strands, in economy & health development, in thinking about communities etc.)

A further factor will be taking into consideration the impact of the increased adoption of digital means of communication to access health care. As services move to contain and limit face to face consultations with the adoption of Near Me and greater use of information promoted on websites and social media, we will be taking steps to understand and address the obstacles for those who do not have access to this form of contact as part of our wider approach to health literacy. Research demonstrates that for many, access to Wi-Fi or mobile data is not routine. Across NHSGGC, actions to support at risk people are being taken with the distribution of devices, funding has been supported nationally with bids to the “Connecting Scotland” digital exclusion programme.

The adverse impact of the pandemic on the most vulnerable group has been widely reported with issues such as homelessness; gender based violence, substance misuse, low paid and gig economy workers and BAME groups has been highlighted. The need to maintain a focus on improving health outcomes for vulnerable groups through tailored and targeted public health interventions will be a priority.

Glasgow is a dispersal city for people arriving to the UK as asylum seekers and refugees. During the lockdown, new arrivals were suspended, dispersal arrangements ceased and people accommodated into hotels. Glasgow Health & Social Care partnership continue to deliver a response to assessing both the health needs and accommodation requirements for these cases. Glasgow Homelessness Asylum & Refugee accommodation team work in conjunction with the Home Office, the Mears Group and interpreting services to source suitable accommodation options for those families and individuals who have leave to remain status.

The health needs of individuals and families are supported and with close working with the Home Office, the Mears Group and Migrant Help. Initial health screening is delivered to all new arrivals with particular priority given to families and pregnant women. Additionally, access to prescriptions and their delivery is maintained by staff whilst more specialist health pathways are negotiated for those cases whom are deemed vulnerable. Close dialogue is maintained with the Mears Group and Migrant Help to identify any cases that may require further assessment.

Beyond this, for those cases with leave to remain status, the Bridging Team ensure pathways are in place for families and individuals to access primary health care and where relevant, access to specialist secondary health care particularly psychology and mental health services.

NHSGGC is committed to performing EQIAs for new policies, creating new services or making changes to existing services. Conducting EQIAs is a legal duty relating to the Equality Act 2010 and helps us provide services that are sensitive to inequalities and meet the needs of our diverse community. This means that we work in a way that removes discrimination, promotes equality of opportunity and fosters good relations between people who have a protected characteristics and people who don’t.

The Remobilisation Plan outlines a coherent, prioritised recovery programme which recognises the needs of patients and service users alongside retaining flexible capacity to address potential future surges. To be effective the EQIA must be a process that assesses individual service changes during the period of recovery and redesign.

2.5. *Vaccination Programmes*

As reported in the earlier remobilisation plan, disruption to child health and adult vaccination programmes has largely been contained with contingencies developed for individuals and families who are shielding, including additional contacts with parents/carers prior to scheduled routine childhood immunisation appointments in an effort to maximise attendance and vaccination uptake. For those aged 70 years and over, routine vaccination programmes for shingles or pneumococcal have been paused in accordance with COVID-19 guidance, although opportunistic vaccination continues whilst awaiting confirmation of the 2020/21 shingles vaccination programme from Scottish Government.

Planning for the 2020/21 Influenza vaccination programme, both for patients and health and social care staff, continues at pace. Initial work to scope out the context and challenge of conducting this within the context of COVID-19 has been completed, with work to identify feasible alternative delivery models well underway, considering GP practice, locality and Board wide models. Estimates of demand indicate that with expanded eligibility criteria along with an expected higher uptake, the volume of people we will need to vaccinate may be double that of previous years, with an increase in associated costs.

Constraints in traditional service delivery models/capacity determined by compliance with COVID-19 infection control precautions may result in capacity being reduced to a third of what would normally be available. The foundation will continue to be a primary care delivered service but this will need to be augmented by additional arrangements.

In relation to seasonal flu vaccination for routine and expanded cohorts, work to explore alternative delivery settings and workforce to GP practices for the adult flu programme commenced in 2019/20 as part of the wider Vaccination Transformation Programme; following the transfer of service delivery of all routine childhood immunisations to community clinics in 2018/19 delivered by a new pre-school immunisation team. Accommodation such as existing community clinic venues as well as larger community venues are being considered to support service delivery in the context of COVID-19 public health measures.

With regards to the vaccination of health and social care staff, the traditional mass drop-in staff flu vaccination clinics will not be feasible in the context of COVID-19. As a result, the programme for 2020/21 will have to be delivered differently with more peer immunisation for clinical teams, this becoming the main route for staff immunisation, with effective local ownership and responsibility for delivery at every ward and department level required. A system of Peer Immunisation will be mandated this year with all clinical areas required to arrange peer immunisation for their staff. This will be delivered alongside a tailored programme for non-clinical staff delivered by Occupational Health, operating on an appointment basis. Staff who have been “shielding” will be directed to contact their GP for vaccination.

For social care staff, the main delivery route will be peer immunisation, alongside delivery through community pharmacies for mobile social care staff such as home care staff.

Both the Adult Flu Planning and Staff Flu Vaccination Planning groups reconvened in June, with membership of both groups reviewed and expanded. Planning continues at a pace, with plans to be finalised by early August.

Planning will take into account both routine vaccinations and the potential for a COVID-19 specific vaccination, likely to be later in the flu season. Health and social care staff will be a priority group for COVID-19 vaccination. Important learning from the staff flu vaccination programme will help to inform delivery.

The associated costs of delivering seasonal flu vaccination to expanded cohorts, with uptake expected to increase, as well as the costs associated with delivering a COVID-19 vaccine to health and social care staff, are currently being finalised and initial estimates indicate a potential financial impact of £3 million.

2.6. *National Screening Programmes*

The five national screening programmes (Breast Cancer, Bowel, Diabetic Retinopathy, Cervical Cancer and Abdominal Aortic Aneurysm) have all recommenced in line with national direction, addressing the backlog of patients who had been cancelled at the end of March. We anticipate that even with the restricted capacity, the backlogs will be cleared by the end of August with the possible exception of screening colonoscopies following a positive bowel screening test.

Recommencement of routine screening programmes is anticipated from September. We foresee significant challenges in meeting the demand for diagnostic procedures like colonoscopies for bowel screening and mammograms for breast screening due to the stringent requirements imposed by COVID19 infection control that reduce the service capacity and the additional competing demands from the symptomatic services.

2.7. *HIV Outbreak in People who Inject Drugs and Elimination of Hepatitis C*

A further priority for the Board is to address the outbreak of HIV in people who inject drugs and ensure we continue to work towards the elimination of Hepatitis C as a public health threat by 2024.

New transmission of HIV is continuing among those who inject drugs, with 13 cases identified so far in 2020 and cases with links to the outbreak now identified in HSCP areas other than Glasgow City. Data from the national bio-behavioural survey (NESI) has confirmed an on-going undiagnosed HIV positive population in NHSGGC.
As a result of COVID-19, service models have changed to accommodate government advice which has meant significantly less face to face contact and as a result BBV testing has dramatically reduced across key services including alcohol and drug recovery services.

A number of challenges have been identified to resuming pre-COVID-19 testing levels linked to staffing and facilities. At the same time we are aware that the new service models implemented due to the pandemic have been well received by users and staff. Alcohol and drug recovery services recognise the importance of the BBV testing agenda but unless we make the other changes discussed below it will not be, possible to return to pre-COVID-19 BBV testing levels this year.

It will be vital that increased testing is achieved to ensure our ability to operate an effective treatment and prevention strategy; reduce the likelihood of undiagnosed infection going

untreated and onward transmission of BBVs; and reduce late diagnosis. Given the higher prevalence of Hepatitis C in NHS Greater Glasgow and Clyde compared with other boards, achieving adequate testing is essential to Scotland achieving its targets on the elimination of hepatitis C as a public health threat by 2024.
The priority will therefore be to ensure testing occurs in key services when face to face contact takes place including acute assessment and emergency departments and to support key services such as alcohol and drug recovery services to find solutions to the challenges faced, including supporting any short-term contingencies / 'catch-up' initiatives. Treatment teams are starting to explore how to restart more routine activity as part of the recovery plan for their sector/organisations. Further detailed work will be carried out on this over the next 3 months and an action plan with timescales will be produced.

2.8. *Active travel*

During lockdown levels of walking and cycling rose in Scotland as a means of exercising locally (see Cycling through a pandemic & Walking during lockdown). At the same time motorised traffic and congestion reduced leading to immediate reductions in air pollution and carbon emissions.

As lockdown restrictions are eased and people start to go back to work there is debate about whether these positive trends can be sustained. Car use has increased almost to pre-lockdown levels and, with concerns about using public transport, there is a danger that car use will become even more prevalent than before lockdown.

To avert this regression, local authorities and other public bodies could consider new infrastructure to support safe active travel which enables social distancing, through schemes like Spaces for People. Glasgow City Council is already using funding from this scheme for road space reallocation to build temporary active travel routes, reduce on-street parking, close 'rat runs' (whereby residential streets are used by drivers during peak periods to avoid congestions on main roads) and create school car free zones.

A communication campaign backed up with incentives is also needed to encourage people to return to public transport. As an example, in February the Scottish Government agreed to provide free bus use for under 19s (https://www.bbc.co.uk/news/uk-scotland-scotland-politics-51644373 a move that would encourage affordable bus use, helping one of the age-groups worst affected socio-economically by lockdown restrictions. In another development free bike hire of Glasgow's nextbikes has been enabled which will encourage more people to switch to active travel; the scheme appears to attract more women to cycling.

In the longer-term a whole system approach to sustainable transport planning is needed with multiple interventions, including the following:

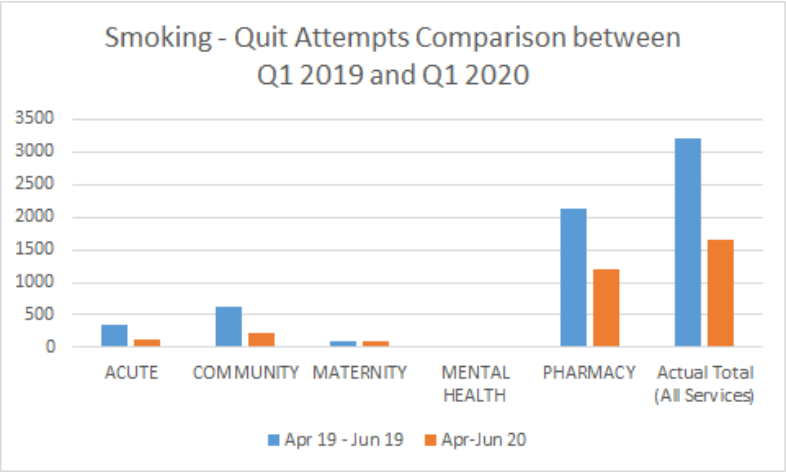
- greater investment in active and public transport and reduced investment in roads and incentives that encourage private car use.
- integrated ticketing across public transport modes (train, bus, underground and bike hire) and providers would help to make public transport a more attractive, affordable and convenient option.

- reducing the speed limit to a default 20mph in urban areas will reduce road casualties and encourage more people to walk and cycle (Wales is moving to a 20mph speed limit in residential areas).
- investment in active travel needs to focus on building comprehensive networks of safe walking and cycling infrastructure.
- a focus on approaches to reducing the impacts of transport inequalities, and ensures access to safe, affordable sustainable transport options.
- As an NHS Board, we are committed to work with partners to promote physical activity and make it easier for people to use active travel rather than cars.

2.9. *Smoking Cessation*

Smokers are already at an increased risk of contracting respiratory infections and of more severe symptoms once infected with COVID-19 resulting in higher rates of hospitalisation and deaths. This is in addition to the other health risks associated with smoking as well as the financial inequality. We observed a reduction in the number of people quitting during the initial period of the pandemic but more recently, the numbers have started to increase albeit not yet at the "pre-pandemic" levels which we will redress and improve on. Specific attention given the emerging evidence on the impact of COVID-19 will be on BAME communities, Quit Your Way services and marketing will be reviewed to ensure smokers within BME communities are appropriately targeted.

In NHSGGC Quit Your Way services are already targeted at our most vulnerable population groups, including those in our 40% MDD and pregnant women. In comparison with same period 2019, engagement figures in all areas have reduced, with the exception of pregnant women which has seen a slight increase in referrals. We will therefore be implementing learning from previous successes including work with community pharmacies, primary care, acute services and social media campaigns to improve referral rates



Traditionally Quit Your Way services have been offered in group sessions, during lockdown this has transitioned to telephone engagement. Going forwards service referral and engagement will align with wider health and social care appointment systems such as Near Me. The need to address digital exclusion is discussed in other sections of this plan.

Given public concerns about COVID-19 and changes in social behaviour, this is a good time to promote existing smoke-free grounds policies in preparation for legislation expected later this year.

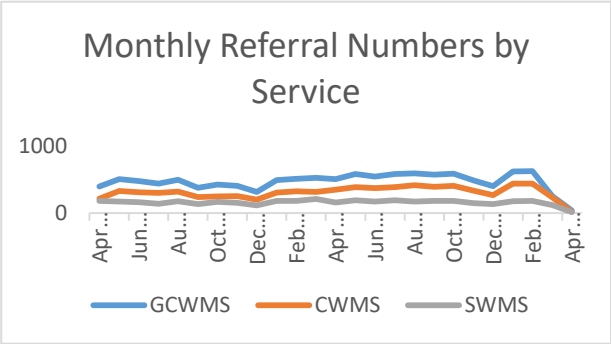
2.10. *Weight Management*

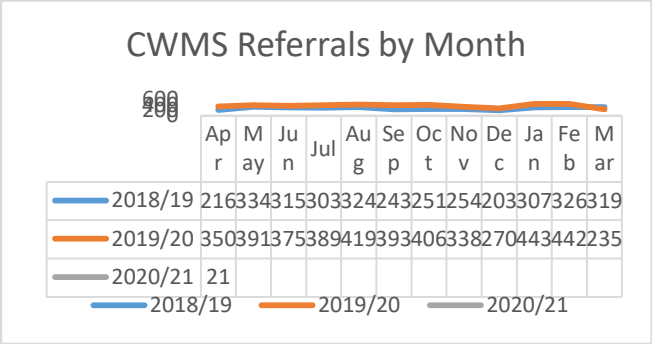
Prior to the pandemic, there was already recognition that healthy weight and the increase in Type 2 Diabetes is a national concern. In response, Scottish Government has resourced a national strategy to tackle overweight/obesity and Type 2 Diabetes.

During lockdown public health information and advice was developed and disseminated across a range of digital networks & social media platforms. This has been well received by partners and useful in the efforts to test and protect. Subsequent to the pandemic lockdown, it is anticipated that food insecurity and poverty will become more challenging and for more people. Further development of these resources as part of wider food policy development alongside healthy eating messages is essential to support our most vulnerable populations.

During the pandemic, face to face community weight management and physical activity services were suspended in favour of online /digital support.

Whilst commercial and public sector partners developed online services at a significant pace – and for some patients, these have been really useful however, there has been a significant reduction in both referral rates and engagement with the supports available and this requires further exploration to enhance our understanding of the reasons why and how we can mitigate this in light of prolonged measures in response to COVID-19.





From July 2020 our contracted services provided by Weight Watchers will provide two options of membership:

- Digital only (WW app and virtual Workshops)
- Face to Face (WW app and 'Express' face to face workshops

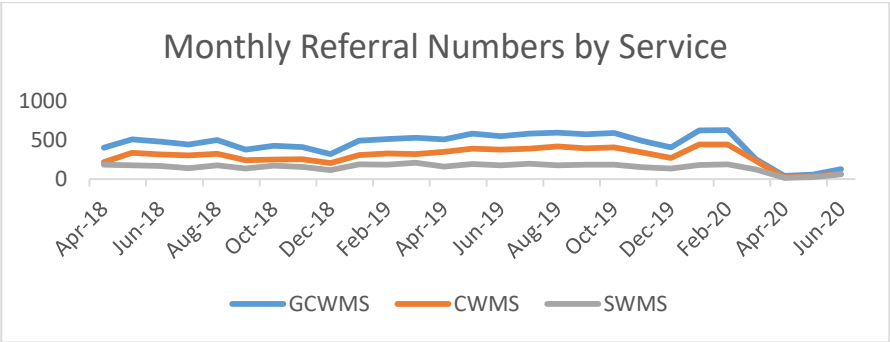
WW have carried out risk assessments of all venues and presented the Board with a Back to Business plan detailing service delivery changes to comply with SG COVID-19 guidance.

Adolescent weight management services, provided by Slimming World are also undertaking similar risk assessments. Face to face services are dependent on Glasgow HSCP Youth Health Services, delivered in primary care settings. A scoping exercise of all

delivery venues is being carried out currently with face to face services being resumed in line with primary care recovery.

Type 2 Diabetes structured education programme will be piloted using 'Near-Me' platform at the end of August – this is in agreement with primary care referrers, with a face to face option being considered for those who are unable or unwilling to attend digital services.

Data in relation to the engagement rate up until end June demonstrates that actions to increase knowledge of digital services through geo-targeting of advertising by our partners has resulted in a slight increase in the engagement rate which is encouraging.



Work has begun with Glasgow HSCP to explore alternative methods of delivering healthy eating and physical activity programmes to families to increase our early intervention efforts and a bid is being developed in partnership with GHSCP for submission to SG by 1st September.

Early intervention programmes aimed at Pre-5's and families were planned before the lockdown. Plans are underway to re-start these pilot programmes, but the start dates are dependent on relaxation of SG restrictions.

Work that was detailed on the T2D implementation plan in relation to 'Counterweight' (LC/LD) for newly diagnosed patients will be re-started by community dietetics using 'Near Me ' platform. The timescale for this is dependent on primary care/community settings and discussion with diabetes MCN re this is ongoing. It is anticipated that this programme will re-commence before the end of this year.

The programme aimed at reducing gestational diabetes is also planned for this year. It is anticipated that this work will be re-started before the end of this year, but is dependent on NHSGG&C maternity services.

Physical Activity programmes, Vitality and Live Active are still being delivered using telephony and referrals to online supports. Recovering face to face support for patients will be dependent on SG restrictions on LA gyms. We are working with local authority leisure providers to re-start face to face support in line with guidance as soon as restrictions are relaxed.

2.11. *Public Health Capacity & Resilience*

The COVID-19 pandemic has emphasised the relevance of many of the priorities described in our Public Health strategy "Turning the Tide through Prevention".
By invoking our Business Continuity Plans and redirected staff to the emerging public health emergency we were able to respond to the challenges over the last few months. This was further supported by mobilisation plans that ceased non-essential activity; staff relocation scheme; and the bank service that allowed staff with relevant skills to be deployed to meet the much enhanced heath protection function.

Coronavirus persistence and the risk of a second peak require ongoing enhanced health protection function to deliver the Tier 2, Heath Protection specialist element of Test and Protect. Boards have also been advised to strengthen core Health Protection teams to build the resilience necessary to assess and respond to the ongoing impact of the lock-down period. Our plans for additional staffing have been developed with the national planning on Test and Protect and the Scottish Directors of Public Health Group.

Band	WTE	£
5	3.0	124,200
6	2.0	103,000
7	8.0	486,400
8B	1.0	85,100
Total	14.0	798,700

The above resources do not include consultants in public health as we currently have 2 vacancies to which we were not able to recruit earlier this year. However we would hope that over the next year we will be able to recruit to consultant posts. In addition to these public health staff as part of the specialist health protection team, there is also a need to strengthen the resilience of the directorate with new senior posts. These posts will have a management role to support health protection and recovery across the whole range of our public health responsibilities. Two temporary post are already being utilised to support establishment of Test and Protect and the overall management and leadership of DPH. Further work is taking place on the costs of the senior posts over a 2 year period but they are likely to approximate £200,000 per annum.

The impacts of the pandemic on mental health and on health inequalities are well recognised in this plan. It will be crucial to strengthen local community support and resilience through joint working amongst communities, the voluntary sector and public health. We are undertaking further work on the details of the requirements based on evidence of what works and on detailed costs. Costs are likely to approximate £150,000.

2.12. *Care homes*

Care homes have a vital role to play in providing a safe, caring environment for people to live. In Greater Glasgow & Clyde (GGC) we want to ensure staff can continue to care for the most vulnerable in our society during the COVID-19 Pandemic.

Elderly people and those with underlying medical conditions (especially conditions that place people into the 'extremely vulnerable group) are particularly vulnerable to COVID-19 virus, this is even more so for those people living in local authority, independent and Third Sector care homes where a significant proportion of them will be living with frailty, many

will have multiple health conditions and physical dependency, and some are in their last year of life. Recent experience has shown that outbreaks of COVID-19 in care homes have proven to be devastating and it is clear that care home residents have a particularly guarded prognosis if they become hypoxic secondary to COVID-19.

Whilst the majority of care homes in NHS GGC are for elderly people, there are also 56 homes for other care groups such as people with mental illness, addictions, physical disability and learning disability. These homes have not experienced the outbreaks of COVID-19 seen in the older people homes but we continue to work with these homes to ensure good infection control and to support weekly testing of their staff as well as rapid testing of residents or staff with symptoms.
GGC is committed to providing coordinated support to care homes and residents, and public health teams will work in conjunction with other professional leads across the health and social care system to provide:

- Leadership and enhanced assurance by the Director of Nursing supported by the Director of Public Health and Chief Officers
- Appropriate information, guidance and support to safely admit, accept discharges from hospital, and care for patients during the pandemic
- Clear information and the right support to care for people and support care home staff health during and beyond the pandemic
- Equipment and supplies, including Personal Protective Equipment (PPE) for care homes and that staff receive the right training in donning the equipment, it's safe removal (doffing) and disposal so that staff can provide care safely and that they are appropriately protected
- Access to testing for residents and for care home staff, and specialist public health protection support in response to outbreaks (including COVID-19)
- Training opportunities and support to all care homes in GGC e.g. through webinars.

Further information about local HSCP support for care homes is noted in the HSCP section of this plan.

Key Points
• **Review of our Turning the Tide action plan to prioritise where we can have maximum impact and build on changed health behaviours over the COVID-19 period** • **Work with local Councils and other partners to support active travel, target smoking cessation services and support weight management initiatives** • **Monitor daily totals and clusters of cases to ensure rapid, effective management of local outbreaks** • **Maintain a tier 2 contact tracing service to address complex tracing and local outbreaks** • **Work with partners across GGC to mitigate the health inequalities impact of COVID-19 and our societal response** • **Support the drive to increase flu vaccination rates among staff and vulnerable groups** • **Work with HSCP colleagues to support care home staff to protect residents, focussing on clear advice, testing, access to PPE and training**

3. New ways of working- Digital Innovations

NHSGGC host the West of Scotland Innovation Hub. During the COVID-19 response a number of ongoing innovation projects have been scaled up and accelerated.

Digital support for the remobilisation of services in NHSGGC will be essential and will build on the significant response since March 2020. All services will consider a Digital First approach to their re-mobilisation plans in order to embed digital approaches, integrations and innovations and will be supported by the eHealth Directorate. The eHealth Delivery Plan has been reviewed and re-prioritised to ensure alignment with the Boards Re-Mobilisation Plan focussing on virtual patient pathways, enabling better access and new ways of working.

This digital section of the Board's response sets out major programmes of work that will be taken forward and resourced within the NHSGGC eHealth Delivery Plan.

3.1. *ACRT / Virtual Consultations*

The use of technology to support remote consultations is being significantly scaled up. To support remobilisation, the focus is on the use of Active Clinical Referral Triage (ACRT). - ensuring that all referrals to secondary care (including advice and patient-led referrals) are triaged by a senior clinical decision maker to evidence-based, locally agreed pathways after reviewing all the appropriate electronic patient records. The options include virtual attendance, giving patients clinical information and allowing them to opt-in, ordering investigations, placing on a waiting list for a procedure / surgery and face-to-face (F2F) appointments.

An organisational wide Oversight Board has been set up, chaired by the Director of eHealth with Deputy Medical Director as Co-Chair to ensure the implementation is clinically driven and that ACRT implementation is targeted across all relevant services and the opportunities to undertake remote consultations are maximised. The Oversight Board reports to the Recovery Tactical Group through to the Strategic Executive Group and Board Chief Executive. The programme structure has 2 key business areas for delivery (i) HSCP/Community led by the Chief Officer West Dunbartonshire HSCP (ii) Acute led by the Director of Access. Key to delivery will be nominated General Managers and Clinical Leads with operational or corporate support staff co-opted as appropriate.

All deliverables are supported by eHealth and Business Intelligence. An accelerated plan is in place to support services moving to ACRT. eHealth Health Records teams are working with Clinical Service Managers to review existing clinic templates and reconfiguring these within the Trakcare Patient Management System to support ACRT where appropriate.

A checklist of actions to support services over the coming weeks to implement ACRT has been produced. Key actions for services include:

- All referrals to be vetted via an ACRT process by end July 2020
- Clinical Vetting outcomes and Clinic Templates require to be reviewed and updated on TrakCare to reflect Virtual Patient Management.
- Specialty booking rules will require to be updated to reflect the new arrangements.

- Existing patients on the OPWL will require to be re-vetted in line with the new options to provide booking instruction to the administration teams and allow rebooking to commence. This will ensure that patients can be booked in line with clinical priority and longest wait to the most appropriate mode of contact utilising a digital first approach to maximise utilisation of outpatient capacity.
- Attendance at Awareness Sessions will be mandated to be provided for key sector staff
- A checklist of actions has been developed to be provided to services to complete as pre-requisites necessary to meet timescales.
- Near Me sessions have been delivered over 12 days for Acute Services and have been well attended.

Installation of additional equipment continues in order to ensure that outpatient clinic areas are used as flexibly as possible to support remote consultations and also face to face appointments.

A performance management framework has been put in place to set the baseline trajectory

- The percentage of referrals vetted via an ACRT process in Trakcare including a breakdown of the number of patient vetted to each pathway i.e. face to face, telephone, video, Written, Opt in etc. By Specialty and Sector / Directorate to demonstrate areas of variation
- The percentage of patients on the OPWL by mode of contact: Face to Face, Telephone , Video Written by Specialty and Sector/ Directorate
- The percentage of patients seen at clinic by mode of contact: Face to Face, Telephone, Video, and Written in the last reporting period.
- A comparison will be available to show progress made by March 2020 pre COVID-19 and on an ongoing basis every 2 weeks.

There is a steady increase in the use of Near Me which is reported on monthly basis.

Mental Health
A specific focus is on Community Mental Health services and enabling the use of Near Me to support remote consultations across services including Psychological therapies. Additional equipment is being installed to support this (189 installations to date and 52 planned) and staff training in the use of the Near Me system is progressing well. There were 650 Near Me consultations during the week 01/07/20 to 07/07/20.

Primary Care
GP Practices continue to make excellent use of the Near Me and telephone to support remote consultations. The use of Near Me in Primary Care will be considered within the scope of the Virtual Patient Management Group which is overseeing the Board's ACRT implementation programme. In addition GPs will be supported to scale up and implement structured advice referrals into secondary care and community services through the use of SCI Gateway.

New app technology based on existing secure image transfer system is being developed to allow GPs to send photo images into secondary care for triaging and advice aligned with new virtual patient. The app can be installed on mobile phones and a photo taken and transferred securely into secondary care for review. This system will be piloted initially.

- Optometrists – Comms issued directing practices to the National Near Me - To date around 80 Practices have requested access to use Clinical Portal
- Dental Practices – Comms issued directing practices to the National Near Me. 44 Practices have requested access to Clinical Portal.
- Community Pharmacies - 55 Community Pharmacies have asked for Near Me to be set up.

In addition, Patient Initiated Review (PIR) is being implemented whereby, if routine follow up is not required, selected patients can be discharged with the opportunity to re-engage directly with the service if circumstances change, i.e. there is no requirement to return to the GP for a further referral for the same condition.

PIR will be used in conjunction with virtual consultations therefore if patients do choose to re-engage, they may firstly be assessed virtually if this is clinically appropriate and face to face consultation will only be arranged where absolutely necessary.

3.2. *Virtual Patient Pathways & Remote Monitoring*

A number of workstreams are progressing to support virtual patient pathways which add further value to the use of remote consultations.

- Identification of tests and investigations ahead of a virtual clinic appointment and the ability to take the test in the community or patients home. Acute Phlebotomy Hubs have been implemented at pace across all sectors. The Trakcare Patient Management System has been configured to process referrals, orders and results for the activity undertaken in the Hubs. As of 13th July 2020 1,973 referrals had been booked across 9 sites and 1,745 appointments booked.
- Clinic capacity from 10th June until 20th July was 739 slots per week, with clinic templates set at 20 minute slots. Clinic Capacity from 20th July will be approximately 963 slots per week with clinic templates set at 15 minutes slots. Thereafter capacity will be monitored on an ongoing basis and the number of slots will increase incrementally in line with demand to a maximum of 2,000 per week.
- Tracking of investigations and results across services and potentially a range of virtual appointments. Dashboards have been developed to cohort groups of patients for specific remote monitoring, e.g. COPD.

3.3. *Unscheduled Care*

Digital support for the Board's USC programme will be in place across a range of work streams:

- Configuration of core clinical systems including Trakcare and Clinical Portal to support pathway changes and MDT workflows (red community pathway, SATAs, Advanced signposting and Mental Health Assessment Units and OOH services)
- Use of remote consultations and notification systems such as Near Me and digital tools such as Consultant Connect which enables clinicians to provide advice and guidance to other clinicians through the use of a secure app.
- Increased use of SCI Gateway advice referrals.
- Development of new Business Intelligence dashboards to support performance monitoring.

3.4. *Electronic Health & Care Record (EHCR)*

NHSGGC has an integrated Electronic Health & Care Record (EHCR) which delivers a single patient record. There is extended sharing of information to social care practitioners, General Practitioners and Community Pharmacists. Implementations to extend this access to Optometrists and Community Dentists have commenced.

As of end June 2020 nominated staff across the West of Scotland Boards can now access relevant patient records in the East of Scotland systems. This complements the existing West of Scotland Electronic Health Record that is already in place.

Over the coming months there will be an additional focus on the use the Anticipatory Care Plans (ACPs) ensuring that clinicians have online access to the most up to date information about the patient and that they can update and add information to the ACP in real time.

The existing Community Assessment Centres (CACs) have been set up and equipped to use TrakCare for Patient Management including test requesting, appointing and access to the EHCR through Clinical Portal.

Feasibility Testing of New Medicines Discharge Model
Access to clinical portal provides an opportunity for different ways of working – this has enabled the medication supply at hospital discharge via community pharmacy feasibility study in GGC.

Currently there is an average three hour turnaround from the screening of an immediate discharge letter (IDL) and the supply of discharge medicines to patients leaving hospital. As part of the remobilisation plans a feasibility study has been completed on medication supply at hospital discharge via community pharmacy. 39/40 consented patients successfully received supply of medicines from their nominated community pharmacy with the majority of patients having a positive experience and time lags to IDL completion and medicines supply reduced. Further refinement of the model is now required including non-pandemic legal mechanism for supply and reimbursement before considering wider implementation. This model has been enabled through community pharmacy access to clinical portal.

3.5. *Staff COVID-19 Testing / Contact Tracing*

NHSGGC continue to support local Public Health teams in the implementation and delivery of COVID-19 screening and testing policies in line with national guidance.

Asymptomatic staff testing processes have recently been implemented and the TrakCare patient management system has been configured to support testing and reporting on a real time basis. Staff are notified by text message of their result.

In addition eHealth are supporting the ongoing care home testing process through Business Intelligence reporting tools.

NHSGGC is working closely with GGC Public Health team and, Contact Tracers have been equipped to enable the use of the new Contact Management System (CMS) and associated telephony.

3.6. *HEPMA / ePharmacy*

Following conclusion of procurement, implementation of HEPMA has commenced. Due to the additional benefits of HEPMA including supporting remote prescribing the design and build phase of the implementation plan has been accelerated and it is anticipated that a pilot of HEPMA within acute wards will commence before December 2020 with flexible rollout to support a potential second peak thereafter.

An ePharmacy programme is being scoped out to progress a number of further digital prescribing workstreams linked to recovery. The bulk of prescribing in NHS GGC occurs in GP practice and the bulk of dispensing is in community pharmacy. Enabling electronic prescribing by GPs and other prescribers including Community Nurses, AHPs and the wider MDT, including serial prescriptions, would have a significant impact on the need to handle and transfer paper and reduce patient footfall. In addition potential for sending electronic prescribing messages to Community Pharmacy from virtual consultations from newly developed pathways and prior to discharge from hospital would have further benefits.

3.7. *Patient Digital Channels*

NHSGGC continue to find ways to make use of digital technology and methods to support and achieve high quality health and social care services that have a focus on prevention, early intervention and supported self-management. Providing care to patients through a range of digital channels is a key aim within the NHSGGC Digital As Usual Strategy. People will be able to access services through a different channels providing flexibility and convenience through initiatives such as; virtual clinics, videoconference, video outpatients, email, mobile text messaging, mobile Apps, web-chat and continued improvement of website, social media content and web-forms.

The development of a digital platform and patient portal in the West of Scotland in 2018 demonstrated that patient's digital channels can provide significant benefits to patients and efficiency. This development was commissioned by Scottish Government and an Outline Business Case (OBC) set out the benefits that citizens and NHS Boards could achieve.

Given the importance of patient digital channels to NHSGGC services and patients the provision of an online Patient Hub (e-portal) is well underway and will be used initially to provide patients with their COVID-19 test results. The scope will then be widened to notification of other test results and appointment information. The response to COVID-19 has highlighted the need to provide patients with results of COVID-19 tests. Thereafter a range of other laboratory results will be provided through the Hub. Alongside this work there will be developments to support patients accessing their appointment information through the Hub and accessing a range of information previously sent via letter by logging into the Patient Hub.

3.8. *Remote Management of COPD Patients*

A rapid scale-up of a COPD innovation project throughout NHSGGC (phase 1) and at least 2 other Health Boards (phase 2) will take place offering remote management, asynchronous messaging, and anticipatory care planning.

- The system allows COPD patients to opt in to a remote monitoring service. Interim analysis of this cohort patients indicates reduction in admissions and the need for community respiratory reviews.
- In conjunction with Digital Health Institute (DHI) project proposal produced, and funding secured to proceed with scale-up in NHSGGC (phase 1).
- Production of COPD-SCOT website, containing self-management advice, and option to register with the online service.
- Identification of High Risk patients through the current clinical system, and process in place to invite them to register to the service.
- To date 104 patients in this cohort have signed up to the services. The next stage is to scale up within GGC with further patients being contacted and verified as eligible for the service. There will be a review which will lead to scale up into other identified Board areas (still to be agreed). By August 2021 the project will be evaluated and assessed for further procurement.

Next Steps:

- Final batch of high priority invitations scheduled to be sent.
- Creation of patient management application in development internally.

3.9. *Patient Centred Visiting – VCreate*

Implementation of a new system called vCreate will continue. The system provides the ability to use video technology for a range of purposes.

- vCreate ICU – use of video for clinician/patient communication to relatives during COVID-19 pandemic an ongoing use for patient visiting.
- vCreateNeuro – Pilot of patient to clinician transfer of video for use in seizure diagnosis and management in adult and paediatric neurology (four regional centres). Evaluation plans have been agreed with the national Technology Enabled Care Programme and also NSS, completing in December 2020.
- vCreate Care Homes (non-NHS) – 6 week evaluation of asynchronous video between care homes and relatives/families. 10 care homes identified for pilot. Trial ends August/September 2020.

3.10. *COVID-19 Assessment App*

NHSGGC have worked with DHI and NES Digital to develop a new Assessment Tool for use in CACs, ED and SATA. The SBAR styled, structured assessment application can be launched from TrakCare and is currently being rolled out across the CACs and piloted in the EDs and SATAs.

Clinicians use the tool to undertake a structured clinical assessment and examination of patients presenting with COVID-19 type symptoms.

3.11. *3D Telemedicine*

NHSGGC Research & Innovation (R&I) are conducting a pilot study to test the functionality of a novel 3D telemedicine system (provided by Microsoft Special Projects) to remotely assess a patient's condition in visual specialties such as Plastic Surgery. Safety, reliability and feedback data is being collated on the 3D telemedicine system. If successful, the pilot study will then inform the design and size of a randomized study comparing 3D and 2D telemedicine. Machine learning approaches will also be adopted to develop novel tools for clinical measurements using 3D telemedicine.

3.12. *Thermal Imaging*

In conjunction with Thales, the GGC Research & Innovation team have conducted a pilot study to test the feasibility of introducing a thermal imaging test to detect fever in 100 patients being triaged within the Emergency Department. The feasibility study will inform the design and size of larger study using machine learning techniques to further develop and validate the thermal imaging screening test to provide a 'with or without' fever result.

3.13. *InHealthcare Remote Monitoring*

NHSGGC are using the new InHealthcare (IHC) system for remote monitoring, linking with the national programme to implement this system firstly for the remote monitoring of COVID-19 patients who are discharged from assessment centres or from hospital and have a diagnosis of heart failure.

The immediate objectives for remote health pathways are to:

- Support service resilience in the face of a second wave of COVID-19
- Support the recovery and mobilisation of services by facilitating remote triage, assessment, diagnosis and monitoring

Key Points
• Delivering more outpatient consultations virtually, across acute, mental health, community and primary care services • Support the delivery of unscheduled care • Scaling up the learning from our innovations projects supporting remote management of patients

4. Workforce and Workplace

4.1. *Workforce Reflections*

NHS Greater Glasgow and Clyde has been immensely proud of the flexibility, resilience and compassion shown by our workforce throughout the pandemic. Our staff have undertaken roles beyond their normal remits, been re-aligned to support our track and protect service and supported the vulnerable within our community settings.
Our staff have adapted their working practices and embraced technology enabling many of our non-clinical staff to work from home which is a model that will be further explored in this next phase of remobilisation. Many of our clinical staff are also now able to work out with their traditional clinical/office environments which in this interim period will be retained to support our approach to physical distancing.

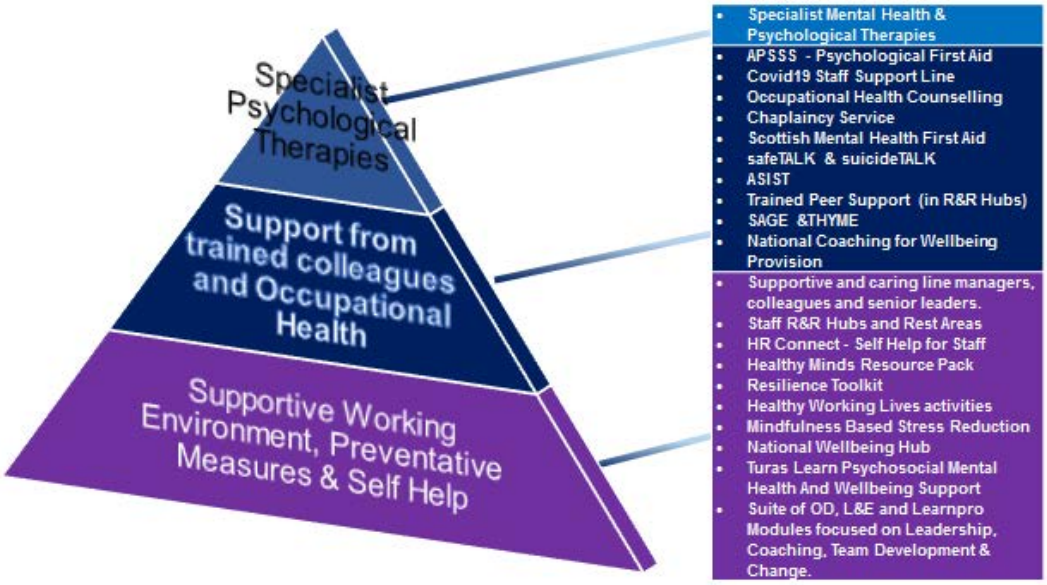
The Human Resources team and the Area Partnership Forum have worked closely together to maximise employee engagement throughout our services ensuring that we respond to matters as they arise and will continue to issue appropriate, timely guidance given the changing demands in the future.

Within this next stage of remobilisation our culture, collective leadership and most importantly employee wellbeing will be key priorities to support our workforce move forward and continue to be supported during the forthcoming periods of uncertainty.

4.2. *Workforce, Mental Health and Wellbeing*

Since the start of the pandemic we have been developing and taking actions to support the mental health and wellbeing of our staff following an evidence based approach aligned to the different phases of the pandemic (Preparation Phase, Mid Phase, Peak, Recovery). This work commenced prior to the national support being introduced to encourage everyone to keep healthy during the unprecedented disruption to daily life by taking care of both their physical and mental health.

Our action plan (NHSGGC Mental Health & Wellbeing Action Plan) has been structured around these phases with actions also categorised in the following tiers:



Regular communication with staff through Core Brief has continued to highlight and update staff on the programme of support available and how and where to access this. A dedicated Staff Support and Wellbeing section within the GGC intranet staff pages provides key resources, links and contacts for support in Mental Health, Physical Activity, Compassionate Distress and Response Service, Skin Health Advice, Spiritual Care, Staff Relaxation and Recuperation Hubs, money advice and protection from abuse.

A gap analysis was carried out to establish areas where further action was needed. For the Recovery Phase the actions have included:

1. The establishment of the NHSGGC Mental Health & Wellbeing Group (chaired by Director of HR & OD and involving the Employee Director) overseeing a joined up and partnership approach to wellbeing planning across NHSGGC which captures learning from early phase response and applying this to Recovery Phase and beyond into Winter and to make arrangements for activities that now need to be permanent. The group brings together Wellbeing Champions across HSCPs, the Board, Psychology, Occupational Health and Organisational Development.
2. Organising Psychology Service resources to support our staff during recovery and potential additional staff support requirements into Winter and beyond.
3. Establishing of a Staff Mental Health Screening Programme, Assessment and Referral Process at 3, 6 and 12 months during Recovery.
4. Development of enhanced Peer Support capability across NHSGGC including support to care home staff
5. Reviewing support to all leaders including coaching and linking to our collective leadership programme
6. Arrangements to make the staff Relaxation & Recuperation Hubs, established during onset of COVID-19, a permanent feature. Using the national PRoMIS site and the new National Helpline through the National Wellbeing Champions Network
7. It is estimated that 20% of staff may require psychological support

In order to ensure an appropriate level of support for our staff and to be able to deliver the plan, short term staff specific psychological and occupational health support is required for

the next 24 months as psychology staff supporting the peak of COVID-19 return to their substantive roles. Costs are included in the finance section of this plan.

4.3. *Workforce Availability*

During the peak of COVID-19 our workforce availability was a challenge. Our greatest need was to have flexibility and predict where the peak demands may emerge. Early assumptions around ICU/HDU activity were supported by staff from other clinical areas augmenting the teams as elective activity was reduced. Our AHP services supported our Community Hubs and many of our community nursing teams supported the vulnerable at home and latterly supported our care homes.

During the peak of the pandemic many of our staff worked long shifts over 7 days and in some cases staff stayed away from their families to avoid potential transmission. As such our Directors and Chief Officers are now supporting as many staff as appropriate to utilise leave through late summer into autumn to ensure rest and also preparedness for winter. Arrangements were put in place nationally to enable staff to receive payment of unused leave from 2019/20, or the ability to carry over excess into 2020/21. A total of 439 staff requested payment for leave, however, this option is available up to March 2021. The local Heads of Human Resources will be working with local managers to maximise leave and linked to our wellbeing initiatives ensure this is monitored effectively particularly supporting staff returning from shielding. Annual Leave usage has begun to increase in June (from 6% to 8%) and this trend has continued into July with the final figure expected to increase to 10%. The rate of annual leave usage can be increased to 11.5% without impacting overall resource availability provided that Special Leave continues to reduce in coming months. This will ensure that staff have the opportunity to fully utilise their leave allowance during this leave year.

Returning to Work – Shielded Staff
There is recognition that it will be challenging for many staff to return to the physical environment having been away from the workplace for over 16 weeks, specific Occupational Health and HR support will be available using the new Occupational Health Risk Assessment and our local Enhanced Return to Work process which has been developed to help discuss the practicalities of a safe return to work, inform the staff member of any changes to their physical environment and explore any areas of concern which the returning staff member may have, including assessing their mental health and wellbeing.

Special Leave usage was at its peak in April (8.2%) but this has reduced in subsequent months to the current rate of 4.5%. A further reduction is expected from the 1st August aligned to the return of some staff who were shielding, however it is anticipated that some staff may not be able to return until a later date. There are currently a total of 1179 individuals absent from work due to COVID-19. The vast majority (997 of the 1179) are absent due to underlying health reasons. The majority of these people will be supported back to work through an Enhanced Return to Work process. It is forecast that 65% of these people will be available shortly after the pausing of the shielding process. The remaining 35% will include those with specific high risk conditions which may prevent them returning to work and this number is expected to reduce to below 10% throughout the autumn as alternate working arrangements are agreed.

Carers Leave

The number of staff not attending work due to childcare responsibilities peaked at 258 in early April, and has undergone a marked reduction from 150 to 83 since the completion of the spring school term in the last week of June. This number is expected to fall further throughout the school holidays and again from mid-August when schools return, when it is forecast that fewer than 10 individuals would be seeking special parental leave, for example for parents of children with additional needs or health conditions. The daily reporting mechanism created to provide analysis of the COVID-19 related absences will remain in place and will be available immediately to report of any future COVID-19 wave. Data on the levels of staff absence experienced throughout the period March to June have been used to inform modelling for the period July to March 2021.

The forecasted reduction in special leave usage means that the anticipated increase in annual leave usage can be accommodated without any impact on overall staff availability. Further reductions in special leave as we progress towards the winter months may offset the typical seasonal increase in sickness absence.

It is forecast that staff availability will remain at 78% for the remainder of this fiscal year, slightly below the average (78.5%) experienced last year. Any shortfall in staff availability will be resourced through bank and supplementary working. The exception to this is pregnant workers as the guidance linked to shielding did not change for those over 28 weeks. Our normal workforce planning assumptions would expect our staff to remain at work for longer in their current roles. The guidance will result in those over 28 weeks either being moved to non-clinical roles or being at home, impacting on backfill arrangements.

Sickness Absence

The current total sickness absence is 5.2% (excluding COVID-19) and is forecast to increase throughout the autumn into the winter period in line with previous year's trends. Long Term Sick absence has remained constant throughout the COVID-19 period. We do expect that some staff shielding are those with long term conditions that may need continued reasonable adjustments through this remobilisation period.
A review is underway to look at staff on long term sick leave, to ascertain if this is due to delays in elective treatment which may impact on sick pay. Much of this will be linking with our working for longer review and the refresh of our Staff Health Strategy.

Short Term Sick absence has reduced by 0.8% from 2.5% in the pre-COVID-19 period to 1.7%. The overall forecast increase in sickness absence can be largely attributed to the latter.

Staff availability quarterly forecast summary:

	Staff availability	Annual Leave	Sickness Absence	Special Leave (including COVID-19)	Other
Q2	78.0%	11.5%	5.5%	2.0%	3.0%
Q3	78.0%	11.5%	6.0%	1.5%	3.0%
Q4	78.0%	11.5%	6.5%	1.0%	3.0%

4.4. *Recruitment*

The Board expects to recruit 667 newly qualified Nurses and Midwifes throughout September and October. The majority of this recruitment will occur on the 1st October as many of these individuals are already working in the Board in an unregistered capacity. As of the 5th August 2020 there will be 1504 Doctors and Dentists in Training (DDiT) on rotation at NHSGGC. In addition to these roles, there are approximately 300 clinical Fellows who will fill the Board's service and training vacancies. As a result of COVID-19 there are a small number (17) of junior grade medical staff whose start dates will be delayed. Aside from the small number of staff with delayed start dates, there is no other COVID-19 associated impact upon DDiT staffing levels.

Projected Recruitment	
Newly Qualified Nurses/Midwives	667
DDiT	1504
Service and Training Vacancies (Clinical fellows)	300
Total	**2471**

NHSGGC have been supporting care homes within the Board's geographical area. A total of 79 shifts have been delivered by nursing staff. 58 of these shifts were completed at one care home. There have been no requests for support since early June. If there is increased demand for care home shifts in the future the Board will support this once again by utilising resource from the staff bank. The staff bank was successfully bolstered through additional recruitment activity during the COVID-19 pandemic.

NHS Greater Glasgow and Clyde has a well organised recruitment model and by using the new Jobtrain system has created a very reactive, responsive service that does not require support from NES Portal going forward.

With the continued reduction of COVID-19 restrictions there is potential for NHSGGC staff to be contacted through the work of the Test and Protect teams. The impact of a new positive case within a healthcare setting is acknowledged. If staff are required to self-isolate and cannot attend their normal work location to fulfil their normal role, efforts would be made to backfill locally. If this was not possible then the utilisation of bank staff is available.

Should there be a significant second wave of COVID-19 cases throughout the winter period, NHSGGC is prepared to recruit additional staff to backfill those unable to fulfil their normal role. The Board demonstrated its ability to recruit at pace during March and April. A significant number of people registered their interest in roles via the NHS Education for Scotland (NES) with whom the Board would rapidly re-engage if future recruitment was required.

The Board also maximised the use of staff in non-clinical roles being realigned. This model supported by the Area Partnership Forum will also be reintroduced should demand require.

A summary of recent COVID-19 related recruitment activity, including new bank staff is shown below:

Job Family	**Recruited March & April**
Administration	-
Medical and Dental	162
Nursing and Midwifery	562
Support Services	351 (Bank)
HCSW	1,550 (Bank)
Total	**2,625**

4.5. *Staff Turnover*

Annualised staff turnover within the Board is relatively constant over the past 2 years at 7.5%. This equates to approximately 0.7% or 225 WTE leaving each month. During the COVID-19 period this has reduced to 175 WTE per month, which has not materially changed the overall rate of staff turnover. The number of leavers is forecast to reduce further given the wider economic landscape. Acknowledging this, there will always be a degree of staff turnover which our recruitment team will manage within its normal activity. A number of staff have opted to delay their retirement during the pandemic in order to support the Board by remaining in post. On average, 56 individuals (48 WTE) chose to retire each month. This number is forecast to increase slightly post-COVID-19 as staff feel able to retire from their post. There may also be an increase in the retiral rate post-COVID-19 as people reflect on their experiences during the pandemic. The backfilling of these posts will again be addressed through normal recruitment activity.

4.6. *Implementation of Social/Physical Distancing within NHSGGC*

The Board is mindful that until a vaccination is found and available within the wider population one of the best risk mitigations is our staff, service users and visitors social distancing. Guidance was developed through the Health and Safety and Estates and Facilities teams to reduce the risk associated with COVID-19 and this is being fully implemented across our Acute, Corporate and our six HSCPs. The guidance document was developed through stakeholder consultation including the Area Partnership Forum. The Guidance includes a detailed risk assessment template that departments and services are expected to undertake to review what controls are in place.

To support implementation of the guidance document a governance structure was implemented and there is a Steering Group led by the Director of Human Resources and Organisational Development and an Operational Group led by the Associate Director of Estates with site based leads across Acute, HSCPs and corporate areas.
Sample risk assessments were developed by the Health and Safety team to support implementation for an acute adult inpatient ward environment, an office environment and an outpatient department.

The process is robust and covers all areas to support patient services returning and recognising the different environments across the Board. The implementation of any physical changes is prioritised based on services currently on stream and preparing for those coming stepping up.
Any physical changes require approval through the Operational Group with funding identified prior to approval.

Along with the physical environment this work includes reviewing guidance on home working and ensuring that new ways of working developed during the peak of COVID-19 e.g. Near Me are continued where appropriate and takes account of staff and patients returning from shielding. Working in partnership with our Area Partnership Forum and staff our expectation is that not all staff will return to the physical environment providing opportunities to introduce technology enabling staff to work differently and for a significant number of our outpatient clinics to be undertaken virtually.

The Interpreting Service is a good example of moving from face to face interpreting to telephone interpreting enabling face to face to be focussed on the most vulnerable. Corporate communications has been key and a full campaign has been used to reinforce the guidance with regular messages for both staff and visitors to ensure everyone maintains social distancing. This will continue to be reviewed subject to any national guidance or change in policy.

Over 928 risk assessments have been undertaken to date with a further 256 identified.

4.7. *Volunteers*

Volunteers have played a key role in supporting clinical staff during the pandemic period. Volunteers have provided around 1500 hours of support per week and tasks undertaken have included:

- Virtual visiting - older people's mental health.
- Providing staff with a 'First Class Airline Lounge' experience.
- Hand Hygiene stations.
- Assisting with emergency patient food packs & patient tuck shop delivery
- Supporting PPE donning and doffing, assisting in the discharge lounge.
- Driving (fleet movement; patient transport)
- Facilities support/ helping domestics / cleaning
- Sorting public donations and delivering across site

Key Points
• **Staff mental health and wellbeing is a key priority for the next 18 months with a focus on delivering our Mental Health and Wellbeing Action Plan.** • **Workforce planning will be key to maintain the level of services required including ensuring appropriate steps are in place to encourage and support to take annual leave.** • **We will be maintaining the skills learned during the peak to ensure we can reallocate staff at short notice should a further peak of activity be required.** • **Shielding staff and those with carer responsibilities will be supported back to work through an enhanced return to work process** • **Maintaining appropriate social distancing is important for the safety of everyone.** • **Volunteers have played a key role in supporting GGC staff**

5. Planned Care

5.1. *Principles and assumptions*

A coordinated approach to the re-start of acute services is being implemented with services across NHSGGC adopting the same approach. The principles set out in section 1.2 are being applied and are guiding recovery.

A number of assumptions have been made in setting out our plans for acute elective care across NHSGGC. Investment in Planned Care in 2019/20 within NHSGGC totalled £28.9m and 2.6m for cancer (both nonrecurring). NHSGGC would require a significant level of investment to maintain a degree of elective activity recognising the Board is starting from a deteriorated position and current productivity is less efficient.

The assumptions are:

Outpatients

- Referral rates will continue to increase steadily over the year, returning to 2019/20 levels in October 2020
- Outpatient activity will steadily increase and return to 80% of pre-COVID-19 levels in December 2020
- Measures for PPE, physical distancing and infection control remain in place
- The principle of patients being seen via a virtual appointment (either telephone or Near Me video technology) will be the primary approach across NHSGGC. In the minority of occasions when a face to face consultation is required, appointments will be scheduled at appropriate time intervals to enable safe patient management
- ACRT (Active Clinical Referral Triage) and PIR (Patient Initiated Review) will continue to be adopted across all specialties within NHSGGC services
- Radiology will return to recent waiting times performance over a period of 12 months assuming available resources; this will impact on waiting times for ACRT ‘straight to test’ pathways
- Anticipatory patient management with bloods and imaging assessment before clinic will be reviewed across all specialties and implemented where appropriate

Inpatients / Daycases

- Emergency admissions (medical and surgical) will increase by 2% from last winter with a similar bed allocation required
- Testing and protecting of surgical elective admissions will be in place with as little staffing cross over to emergency flow as possible. These necessary measures will affect efficiency and impact on inpatient surgical bed capacity in some sites
- Separate ‘red’ and ‘green‘ surgical HDUs (High Dependency Units) will be required in some sites where single rooms are not available to manage the different patient groups
- ICU teams and associated staff maintain a state of readiness to be able to double or triple capacity at short notice to manage any rise in COVID-19 admission rates
- Any increase in ICU/HDU provision for COVID-19 patients will significantly reduce elective inpatient and theatre capacity
- Surgical activity will be impacted by winter in the usual way (planned reduction of elective capacity at peak winter periods)
- Day surgery will be expected as the norm for BADS (British Association of Day Surgery) procedures

Theatres

- Prioritisation of theatres will be for emergency, trauma and obstetric theatres with theatre allocation planned appropriately for expected demand
- Predictions for elective theatre capacity are based on the assumption that elective cases will not be displaced for emergency surgery recognising this is an area of risk particularly for trauma
- Cancer and urgent surgery will take the majority of elective capacity particularly on inpatient sites
- National guidelines from the Royal College of Surgeons and the published Cancer Framework will be used to prioritise patients for surgery and this work will continue to be clinically led through MDTs
- As instructed by the Scottish Government ACS (Assisted Conception Services) have been restarted
- Where local anaesthetic can be used this will be maximised to reduce reliance on anaesthetic consultant capacity
- Re-profiling of sites will be actively progressed to achieve optimum theatre capacity.
- Allocation of capacity will be structured in a flexible way based on priority patient management

Waiting Lists

- Patients will be managed in clinical priority order
- Active clinical review of waiting lists will continue to inform the most appropriate use of available capacity
- Longest waiting patient management will be regularly clinically reviewed
- Use of external capacity will be managed across NHSGGC with some capacity directed towards long waiting patients where possible
- Use of the GJNH and independent sector capacity will be required

5.2. *Progress to July 2020 – Planned Care*

In the Phase 1 Remobilisation Plan NHSGGC outlined a number of areas we were taking action on as we moved into the recovery phase for planned care. Progress to date is described below:

We said we would…….	**Actions to Date….**
Continue provision for COVID-19 patients with flexibility for surges	• Red/green pathways are in place for emergency and elective activity • Services are maintaining a state of readiness; e.g. PPE forward planning; a 'reservist approach' to staffing for critical care adopted with staff refresher training planned as required
Maintain all emergency care	• There is daily frequent assessment of emergency demand with emergency theatre provision extended temporarily in hours as required; some overnight operating has been used to manage the full emergency workload (helping to protect the elective workload). This approach can be adapted as necessary.

	• A flexible approach to staffing is in place to manage the Trauma workload as early as possible. Trauma activity has risen during the pandemic; for example QEUH saw a 12% rise in polytrauma (Trauma Injury Severity Score definition) during April/May compared to the previous 2 years, with QEUH taking 69% of the nationally recorded polytrauma cases.
Commence outpatient services by the end of May	• Outpatient services have restarted with total attendances for NHSGGC in June 2020 back to 55% of 2019 levels • Virtual patient management has been adopted as the primary approach for all appointments where appropriate • An approval process is in place for the re-start of face to face appointments to ensure scrutiny and consistency of approach across NHSGGC, as well as allowing detailed PPE planning • Phlebotomy Hubs have been established to facilitate the virtual approach to appointments; an Outpatient Procedure Hub is currently being piloted in the North Sector to manage other tests/investigations prior to virtual appointments
Address the backlog of urgent and cancer cases, including Endoscopy by the end of May	• Elective surgery has recommenced on all sites • Weekly operational review meetings with senior clinical specialty staff are in place to plan surgery for the backlog of cancer and urgent elective cases; between June and July 2020 NHSGGC carried out 3,139 adult and paediatric elective cases reflecting all highly specialist cancer surgery has recommenced. • Elective surgery is continuing to increase steadily with elective theatre capacity directed towards urgent cancer and prioritised non-cancer patients; further detail on the proposed approach is included in section 5.6 • STAC (Scientific and Technical Advisory Committee) guidance is being followed for operative procedures, with full pre-testing arrangements in place • Elective Endoscopy services commenced during May 2020 for patients requiring urgent review • Some patient pathways have been redesigned to improve efficiency of approach; e.g. qFIT testing of patients on the waiting list established to help prioritise Endoscopy pathways where appropriate
Assess the impact of opening up services on Level 2 /3 care, the need for PPE and the demand for medicines	• Estimations of PPE use completed and operational links with Procurement in place and working well • Comprehensive staff lists held of FFP3 mask fit

	• Ongoing assessment of Level 2/3 care related to operative capacity and allocation of patients to theatre lists • Regular review of medicines availability – no current issues for planned care recovery

As noted in the table above, urgent emergency and semi-urgent elective surgery across NHSGGC has now steadily begun to increase at all sites, this includes the re-establishment of limited LA activity within Stobhill ACH, Victoria ACH, the VOL, and displacement of operative activity for skin cancer patients to the GRI Plastics outpatient department.

Urgent CEPOD (emergency) and trauma activity has remained the priority with each inpatient site flexing operative capacity to limit the delays within acute receiving sites.

Total operative procedures have steadily increased over the last 4 months from 439 carried out in week commencing 6 April 2020, to 1,055 carried out week commencing 13 July 2020.

This increase in elective and daycase activity has been enabled by staff rotas returning to normal and surgical bed capacity returning to base levels. Workforce, processes and capacity reviews have been undertaken to inform the plans for expanding sessions and the allocation of theatre capacity.

Flexible arrangements are in place on a day to day basis with shared specialty lists helping to accommodate cancer patients. Subspecialty patient transfers have taken place to maximise theatre time. Dual operating has been adopted to reduce operative time wherever appropriate. Transfer of urgent patient management across the sectors has been undertaken to balance demands.

Streamed elective HDU pathways have been established to support the gradual increase in complex surgical activity. This is enabling NHSGGC to carry out a range of urgent complex cancer surgery, for example Hepato-Pancreatico-Biliary and Oesophageal procedures recommenced from the 18 May 2020 and the re-establishment of the robotic programme for prostatectomy during June 2020. A recovery plan is in place for robotic surgery to manage and reduce the waiting list.

Available NHSGGC capacity has been augmented during May/June 2020 with some additional capacity through external sessions with Breast and Plastics provision at Nuffield, Colorectal, Sarcoma and Musculo-Skeletal Oncology at the GJNH.

As NHSGGC continues to expand planned care activity there are a number of factors in common with all areas across Scotland that will continue to limit the scale and pace of expansion. These include responding to any subsequent rises in COVID-19 presentations in hospital, managing the impact of winter and continuing to support our staff both those who have been unable to carry out their normal duties (e.g. shielding) at this time, and those who have been supporting the COVID-19 response (e.g. redeployment) often in highly stressful situations.

In addition NHSGGC is in the unique position of providing a large number of regional and national services. Approximately 18% of patients on the outpatient waiting list and 20% of the patients on the TTG waiting list are from other NHS Boards. Many of these patients

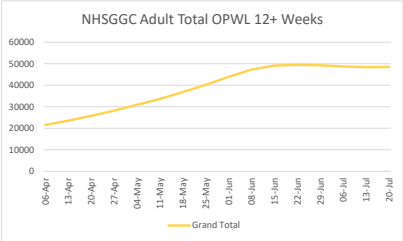
will be waiting for complex assessment and treatment or surgical intervention from small highly specialist teams.

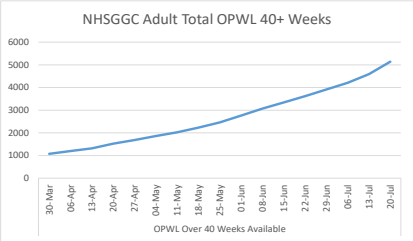
5.3. *Increasing Capacity: Outpatient Services*

Current Waiting List:
As at 20 July 2020, there are 79,606 patients on the OPWL; of these 54,688 patients have been waiting over 12 weeks. A number of patients have been waiting lengthy periods to be seen with 5,142 adults and 227 paediatrics waiting over 40 weeks; of these 904 adults and 24 paediatrics have been waiting more than 52 weeks.

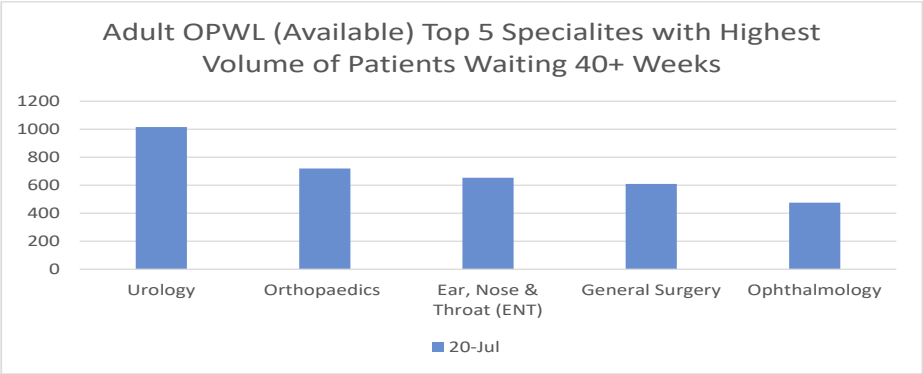
In recent weeks the numbers of patients added to the OPWL has reduced significantly; this is directly attributable to the reduction in referrals and can be expected to continue for a number of weeks whilst referral rates gradually increase.

The tables below shows the weekly waiting time position for patients waiting more than 12 weeks and more than 40 weeks over the 4 months April-July 2020:





Urology, Orthopaedics, ENT, General Surgery and Ophthalmology are the 5 specialties with the highest volume of patients waiting over 40 weeks as at 20 July 2020. Numbers waiting in these specialties are shown in the graph below: (need reformatted as need all 5 specialties)



Outpatient Services have typically been provided through face to face clinic appointments in large, shared outpatient departments. With new infection control and social distancing guidelines in place Outpatient Services have had to adapt rapidly and are currently moving towards virtual patient management (outlined in sections 3.1 and 3.2) as the principle form of service delivery. During this period of change some services have been using alternative accommodation.

All clinic templates are being reviewed and revised to accommodate a blended approach of virtual and face to face appointments. This will involve changes to approximately 12,000 clinic templates.

In addition, some outpatient patient pathways are reliant on timely access to Radiology. The current reduction in Radiology capacity will delay outpatient review in some situations and have a subsequent impact for outpatient waiting times. However efforts are being made to enact Radiology as rapidly as possible. Radiology waiting times will be monitored by local teams and particular issues escalated appropriately. Specific actions for Radiology are addressed in section 5.5

Plans for Increasing Outpatient Capacity:
NHSGCC has made significant progress already in implementing a wide range of changes to increase outpatient capacity and this will continue over the coming months, however as noted previously some factors to increase capacity will be beyond the influence of NHSGGC, for example changes to infection control practices and restrictions on staff shielding which are due to be lifted on 31 July 2020.

Modelling on a number of scenarios has been carried out to understand the potential outpatient waiting list over the coming months.

NHSGGC has set out a wide range of actions to return to activity to nearer 2019/20 levels and reduce outpatient waiting times. These include:

- Clinical validation of waiting lists (specialty focused)
- Capacity plan reviews
- Use of virtual patient management, including adopting ACRT and PIR as the norm
- Group management of patients where appropriate
- Redesign of patient pathways
- Further development of specialist nursing and AHP roles
- Extend the EQUIP (Effective and Quality Interventions and Pathways) programme
- Strengthen Primary / Secondary Care engagement
- Running additional sessions
- Enhancing base capacity
- Further technology developments
- Long waiting specialty specific actions

Clinical Validation and Re-prioritisation of Waiting Lists
There has been widespread clinical validation of waiting lists carried out by clinical teams across NHSGGC during the COVID-19 pandemic. Where national specialty guidelines are available these will have been used by services, however where national guidelines are not in place there may be some local variation in approach. Work is currently underway to consistently record the extent of clinical validation and establish a consistent approach at specialty level where this is not already in place. A regular review of the availability of new guidelines is being supported locally by our Clinical Effectiveness Team. In addition administrative review of longest waiting patients is underway.

Early in the COVID-19 period booked patients were clinically reviewed to ensure appropriate clinical management to investigation or telephone review. Review of new

referrals and unbooked patients has been continuing with clinical teams identifying urgent patients in the early COVID-19 period; however through the use of virtual technologies services have now been encouraged to manage both urgent and routine patients on their waiting lists.

There are a range of specialties where early standardised clinical validation is anticipated to limit the negative impact of delays associated with the COVID-19 period. It is proposed that clinical teams are released from core sessions to actively review the patients on the waiting list using an ACRT approach. A process of review using agreed clinical criteria would offer the potential for insourcing support from other NHS Board colleagues or independent contractors. This would support achieving a significant reduction in patients on the waiting list. Key specialties include:

- Cardiology
- Respiratory
- Orthopaedics
- Urology
- ENT
- Gynaecology

Capacity Plan Reviews
As part of the Level 4 escalation actions, NHSGGC is currently developing a comprehensive set of capacity plans for key services across NHSGGC. This process is now being amended to ensure capacity plans take full account of COVID-19 implications.

Use of Virtual Patient Management, ACRT and PIR
NHSGGC has been an active participant in the Scottish Access Collaborative (SAC) and Modernising Patient Pathways (MPP) programmes which aim to set out best practice for efficient and effective services. Whilst all the workstreams in the SAC and MPP have a significant role to play in the recovery and remobilisation of acute services in NHSGGC, there are some clear priorities for current action. Initial priority actions are those linked to workstreams focussed on increasing and supporting virtual patient management across all GGC specialties (not only the SAC specialty groups).

NHSGGC Acute Division has put in place a comprehensive Outpatient Delivery Framework guiding the approach for virtual outpatient management including ACRT and patient initiated review (PIR). Clinicians have been encouraged to maximise opportunities for telephone or Near Me consultations for USOC, urgent and routine patients as appropriate in order to manage patients safely. Challenging targets have been agreed for use of ACRT and virtual patient management, with services aiming to adopt ACRT in the majority of patient pathways and use virtual options in the majority of outpatient appointments. Increasing use of PIR puts patients in control of their follow-up care enabling them to access support if and when they need this; furthermore it enables services to begin to rebalance the ratio of appointments towards a greater emphasis towards new patient appointments. Sector based Outpatient Delivery Groups led by Clinical Directors and General Managers have been established to cut through challenges and optimise virtual management, share learning to avoid duplication and monitor progress.

Services have gradually increased their capacity over recent weeks and this will continue to develop over the summer period as staff return from summer leave, the IT support

infrastructure is being put in place and staff have completed any necessary training programmes to support new ways of working. Significant investment has been put into IT equipment to facilitate use of virtual technology with e-health currently taking forward a rolling programme providing equipment in all appropriate consulting rooms across our acute sites. Further detail is contained within the Digital section of this Remobilisation Plan.

Group Management of Patients
A number of clinical teams across NHSGGC use group work where appropriate as a key part of their outpatient activity. Group appointments have been suspended during the COVID-19 pandemic as virtual formats to facilitate group contact have been limited. NHS Scotland is currently exploring methods to enable group consultations to be carried out safely and securely. NHSGGC services previously using group management are working with the Scottish Government on this and NHSGGC will be well placed to re-start this work again as soon as possible.

Redesign of Patient Pathways
During the COVID-19 pandemic a number of services took the opportunity to provide services in a different way, redesigning pathways to reduce the number of steps or visits required for patients. An example of this would be the development of Hot Clinics in Urology. Further work will be undertaken to explore additional opportunities for Hot Clinics across all sites in NHSGGC.

Further Develop Specialist Roles:
A wide range of services have already adopted extended roles for Nursing and AHP (Allied Health Profession) staff. Services are being actively engaged to identify any additional opportunity for extended roles across the range of Nursing and AHP. Examples of nurse-led services that could be developed include frailty practitioners or liver services.

Extending the EQUIP Programme
NHSGGC has been at the forefront of the EQUIP programme in Scotland. Orthopaedics and General Surgery teams have been early adopters of the approach offering patients improved access to information early in their pathway and options to opt-in to services as required. Analysis from the Orthopaedic pathways established for some time shows 40% fewer appointments required in an opt-in pathway and the option is received positively by patients. Opt-in pathways are still in their infancy in General Surgery but again are showing significant reductions in the number of patients opting-in.

This EQUIP programme currently covers a limited range of procedures/diagnoses and its impact is being closely monitored. NHSGGC will continue to review patient pathways and new pathways are being added as clinical evidence indicates. In Gastroenterology appropriate patients are qFIT tested and below a defined threshold patients will be offered advice and reassurance only unless other symptoms necessitate investigation. This was a rapid, collaborative piece of work that was clinically led across primary and acute care and supported by senior management. The pathway change was enabled within a few short weeks and the model is being further refined going forward.

It can be expected further pathways will be added to the EQUIP programme over the coming months. This will ensure patients receive the most appropriate response and outpatient appointments are focused on patients in most need.

Strengthen Primary/Secondary Care Engagement
NHSGGC recognises the imperative of collaborative working and excellent communication between Primary and Secondary Care as a means to ensure patients are managed effectively.

In recent weeks NHSGGC has established new arrangements to build on improvements made during the peak COVID-19 pandemic period and strengthen this interface to collectively deliver recovery solutions for our patients. The example of the qFIT test pathway described above is a clear example of this.

Given the changes seen across Acute, Primary Care and community services at this time, the Sector Primary/Secondary Interface Groups will become even more important channels for change.

At a specialty level some clinical teams across NHSGGC have been using Consultant Connect or similar to augment communication with GPs. All areas will be encouraged to review their communication channels and make any changes where this is felt improve coordination of care or our patients.

Additional Sessions
Recognising the significant backlog in patients waiting, additional sessions could be provided in addition to base capacity. Typically these additional sessions are provided by staff taking on additional hours at evenings and weekends to hold waiting list initiatives (WLIs). With virtual patient management this has greater appeal to clinical teams.

In previous years WLIs, and also insourcing options, have been used with additional resource to help manage waiting times and this would be an area NHSGGC would seek to explore in 2020/21. Should resource be available, NHSGGC would be able to switch on additional sessions to manage the backlog of patients on the waiting list.

Further Technology Developments
As part of phase 1 recovery NHSGGC developed Phlebotomy Hubs to provide efficient pathways that support the use of virtual technology. Extending this approach an Outpatient Procedure Hub has been established as a pilot in the North Sector. The Outpatient Procedure Hub will provide all specialties with a single point of access for other tests and investigations (e.g. height, weight) often required before an outpatient appointment. Results from tests will be available to specialties prior to the patient's virtual outpatient appointment. The outcome of this pilot will be reviewed and will be rolled out quickly across NHSGGC if successful.

The provision of high quality patient information is a key priority for efficient management of patients. NHSGGC will continue to build on patient information approaches to optimise the final clinical engagement. This will include the development of more video and other online resources to support patients and referrers; for example FAQs, training materials for patients/general public, as well as standard advice to referrers.

Long Waiting Specialty Specific Actions
For those services with particularly long waiting times the following additional actions have been agreed with the clinical teams:

- **Urology:** teams are adopting the principle of managing the patient at the first point of contact, reducing the need for return visits; teams have implemented consultant and/or

protocol led vetting; a small number of hot clinics have been used during the COVID-19 period and will be re-assessed going forward

- **Orthopaedics:** there will be system-wide adoption of opt-in, ACRT and PIR pathways with more opportunity for advice at the point of referral; greater use will be made of virtual management and advice in the management of Tertiary referrals; staffing and facilities in each Sector will aim to support the management of unscheduled care (virtual or face to face) with rapid access to Radiology, rather than admission into hospital to get prompt diagnostic tests.
- **ENT:** teams are already using virtual patient management and will further adopt ACRT and PIR pathways to facilitate appropriate patient management
- **General Surgery**: teams are implementing a range of measures including use of hot clinics, more one-stop services e.g. Breast, better management of tertiary referrals, full implementation of ACRT and PIR, and General Surgery have been at the forefront of the EQUIP programme and will continue to lead the way in changing patient pathways
- **Ophthalmology:** teams have established some use of telephone triage clinics for enhanced vetting of patients for attendance requirement; greater use of virtual clinics is being considered where appropriate

Maximising Productivity
Use of outpatient clinics and levels of activity will be closely monitored by service teams to ensure use of sessions is maximised. Current weekly performance monitoring is being enhanced to ensure a rigorous process is in place covering all aspects of outpatient recovery plans.

Through implementing the full range of measures discussed above, NHSGGC will aim to achieve 80% of 2019/20 levels of outpatient activity by December 2020.

5.4. *Endoscopy*

Current Waiting Times
The majority of planned NHSGGC Endoscopy Services were paused in late March 2020 with emergency and some inpatient endoscopy procedures continued across acute sites. Limited Endoscopy sessions re-commenced in May 2020.

Endoscopy has been delivered in recent years through 194.5 base sessions across 8 sites augmented by approximately 34% additional capacity in the form of WLI at weekends, GJNH provision, and locum endoscopy activity. In 2019/20, 42,221 scopes were delivered from the base, 3,571 scopes were undertaken through insourcing of private activity, whilst a further 1,183 scopes were delivered through GJNH. This together with revalidation of lists achieved a positive position of 660 patients waiting over 6 weeks at mid-March 2020 just prior to pausing Endoscopy services.

Since May 2020 the base session delivery has recovered to 44%, however patient throughput has reduced from an average of 6 patients per sessions to 4 patients per session due to COVID-19 limitations. The limitations relating to upper GI Endoscopy as an AGP are significant.

As at 24th July 2020 there were 6,827 available patients on the new patient waiting list for an endoscopy appointment, of these 3,060 were USOC and urgent patients and 3,767 were routine patients.

There are 14,535 patients on the Repeat Waiting List. These are a combination of short term repeats and surveillance patients. In the last 12 months new guidance for polyp surveillance has reduced the numbers of patients requiring a surveillance colonoscopy. The process of review will be re-started to remove those who no longer require a repeat endoscope or can move from 1 year to 3 year follow up. Full clinically led review of the repeat waiting list will also identify patients suitable for ongoing management utilising new technologies.

USOC and Urgent Management
Current capacity is being directed towards priority 1 and 2 patients. During 2019/20, an average of 760 new patients each week were added to the endoscopy waiting list. Referral rates during the COVID-19 pandemic have reduced significantly to less than 200 for most weeks. However this is beginning to rise again with 300-400 new patients added to the waiting list each week in June 2020.

Bowel screening was paused during the COVID-19 pandemic however 440 patients were already under review. qFIT result information was recently shared by public health and this is enabling a further clinical prioritisation of patients to ensure appropriate allocation of available resources.

Clinical prioritisation of cases has been undertaken across all Sectors and continues with a new evidence based process agreed utilising qFIT testing for assessment of patients awaiting Colonoscopy. The patients receive a qFIT test through the post and are asked to carry out the test at home and post back. Early analysis of responses to home testing are promising. Clinical discussions will be finalised for patients with a qFIT less than 10 to ensure patients are not over-investigated and are provided with clinically appropriate care and advice.

Plans for Increasing Capacity
As with all services some factors to increase capacity will be beyond the influence of NHSGGC; for example changes to infection control practices including limitations of facilities on some sites meaning temporary arrangements are in place.

NHSGGC has a number of actions underway to increase the level of activity and reduce Endoscopy waiting times. These include:

- Enhance staffing arrangements
- Review of site arrangements
- Review and implement changes to AGP(Aerosol Generating Procedure) Guidance
- Use qFIT testing
- Introduce new procedures
- Make use of external capacity
- Management of long waiting patients
- Enhance base capacity
- Review of decontamination support

Enhance Staffing Arrangements
National (British Society of Gastroenterology) Guidance now requires pre-testing of patients to be carried out for elective outpatient scopes 1-3 days before procedure. Pre-

endoscopy COVID-19 testing clinics have been set up across the sites and are currently being staffed by the core endoscopy nursing team.

These arrangements will be reviewed with the aim of establishing alternative arrangements that can release the endoscopy nursing staff group to provide additional endoscopy lists. Centralised testing arrangements is being considered.

Review of Site Arrangements
Due to changes to national guidelines on managing infection risk (air exchange challenges), changes in infection control requirements mean a number of facilities require upgrade. Work is underway at GRI, with review at VACH and RAH progressing.

Changes to AGP Guidance
Any further changes agreed nationally to AGP guidance will enhance patient throughput in endoscopy sessions.

QFIT Testing
Processes have been put in place to assist prioritisation which makes use of qFIT testing for listed patients. In addition a new administrative process is being established to hold referrals for patients who have had qFIT checked but no result by time of referral, provide qFIT testing kits to patients referred by practices who cannot access qFIT and to follow up patients not completing qFIT. This collaborative approach is supporting timely referral of patients from primary care whilst also overcoming practical limitations that may delay patient referral and review.

New Procedures
There are three alternative types of investigation being explored with support from the Scottish Government:

- Capsule Colonoscopy is a new modality to investigate the colon. A small capsule containing a video camera is ingested and takes a recording of the large bowel that is subsequently analysed. NHSGGC has been approved for Wave 1 implementation of this procedure. Recognising the requirement for further investigation it can be estimated that an NHSGGC service would lead to approximately 250-300 patients per month being investigated in this way, with 80-120 patients not going on to a full colonoscopy, and therefore this will improve the waiting list.

- Cytosponge is a 30mm compressed sponge sent for cytology and molecular markers. It is a validated outpatient procedure for Barrett's screening and can also be used as an alternative to upper GI endoscopy for patients with long-term reflux disease. HPS have confirmed this is not an AGP process. Current Scottish Government guidance for commencement is October 2020 with supporting resource.

- Transnasal Endoscopy is an outpatient procedure without sedation where a thin endoscope is used to examine the oesophagus, stomach and duodenum. Biopsies can be taken and no open suctioning is used. With reduced patient recovery time increasing the patient numbers that can be accommodated.

Optimising Patient Management
ERCP (Endoscopic Retrograde Cholangiopancreatography) management of patients can be optimised to avoid an overnight admission. Pathways for same day ERCP will be

standardised through use of criteria-led discharge and optimal list configuration to avoid inpatient admission.

Golden Jubilee National Hospital /External Capacity
Saturday WLI lists have been core in delivery of the endoscopy service for several years. Whilst this relies on pickup from substantive staff, the average number of lists delivered in 2019/20 were around 14 lists per week delivering approx. 4,000 scopes.

Golden Jubilee National Hospital: The Golden Jubilee National Hospital previously delivered approx. 4 lists per week for NHSGGC patients delivering 1,183 scopes. Capacity on each session there is reduced to 4 cases reflecting the national position. At present however the Golden Jubilee National Hospital is offering staffed lists only for the delivery of endoscopy with NHSGGC operators required to deliver this service. Longer term recovery should see these operators return to base service delivery.

As part of the 2018 NHSGGC endoscopy recovery plan, use of the insourcing through the independent sector in delivery of endoscopy capacity has been in place since November 2018. This generated delivery of 12 endoscopy lists per weekend operating from QEUH every Saturday and Sunday.

Management of Long Waiting Patients
A number of strategies will be considered to better manage the longest waiting patients, including:

- Develop model enabling safe removal of patients from existing waiting list using criteria-led triage
- Implement safety-netting for patients with ongoing or severe symptoms
- Develop systems for monitoring and reporting of long term outcomes for patients removed from lists

Enhancement of Base Capacity
NHSGGC typically used 34% additional capacity prior to COVID-19 to manage the recent demand that was non-recurring funding. A further review of base staffing resource is being carried out and plans for additional capacity are being generated which will require recurring resource.

Decontamination
A full impact assessment will be carried out on increasing sessions for decontamination of equipment.

Due to COVID-19 limitations patient throughput is reduced by 33% in each Endoscopy session. However implementing the combined proposals described above, the service will aim to achieve 45% of the 2019/20 activity incrementally by the end of March 2020, with the exception of upper GI Endoscopy where the aim will be 35% given the AGP and ventilation limitations.

5.5. *Radiology*

Similar to other services radiology capacity reduced significantly during the pandemic. This had led to increases in the numbers of patients waiting for a diagnostic test. Prior to the pandemic, our Radiology services had successfully focussed on clearing any

diagnostic reporting backlog within NHSGGC so we entered the pandemic phase with very little in the way of reporting or image acquisition backlog. At the start of the pandemic, Radiology services were quick to categorise their workload into six distinct categories:

COVID-19 Book		**COVID-19 On Hold**			
Urgent Cancer	**Urgent Non-Cancer**	**Category 1**	**Category 2**	**Category 3**	**Category 4**
Cancer staging examinations where treatment is being considered New suspicion of cancer where treatment is being considered	Examinations to assess treatment response where treatment may change as a result of imaging	Examinations where there is suspicion of malignancy that were not performed during COVID-19 crisis	Examinations to assess treatment response that were not performed during COVID-19 crisis Examinations to diagnose and/or treat significant disease or injury and/or alter treatment plan	Further investigations after a positive screening exam (e.g. CT aorta, CT colon) Routine surveillance of patients on a cancer pathway	Examinations to diagnose and/or treat minor disease or injury, where delay unlikely to be harmful Low risk lesion follow-up (nodules, etc.) Screening exams

Patients vetted into “COVID-19 Book” were booked for imaging at all stages of the pandemic. From very early on category 1 patients were also booked. During April/May category 2 and category 3 patients were booked in line with lockdown restrictions. Category 4 patients are now being booked where capacity allows. However during COVID-19 a waiting list has developed in the main relating to category 3 and 4 patients. It should be noted that there is no image reporting backlog.

The table below shows three potential outcomes for diagnostic waits > 6weeks. The first (‘no additionality’) assumes no real change to current capacity and ultimately in this scenario the numbers of patients waiting over 6 weeks increase by circa 2,000 scans per month resulting in a position at the end of March 2021 of 32,000 patients waiting > 6 weeks.

The second scenario (‘all actions less CT pods’) assumes that the service is able to implement a comprehensive range of measures to increase imaging capacity and enable the service to reach a significantly improved position by March 2021. However this scenario assumes that NHSGGC does not have access to additional CT capacity from either of the two CTs procured by the Scottish Government.

The third scenario (‘all actions including CT Pods’) assumes that the service is able to implement a comprehensive range of measures to increase imaging capacity including access to the two CTs procured by the Scottish Government.

Imaging												
Year	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
2020-21 Recovery Position - no additionality				14,609	16,779	18,949	21,119	23,289	25,459	27,629	29,799	31,969
2020-21 Recovery Position - all actions (less CT Pods)				14,609	13,495	12,386	11,277	10,168	9,059	7,950	6,840	5,731
2020-21 Recovery Position - all actions (inc. CT Pods)				14,609	12,935	11,266	9,597	7,928	6,259	4,590	2,920	1,251

Recovery postion Based on internal capacity, additional session, GJNH
Recovery postion assumes 4% increase in referrals as per 18/19, 19/20 demand

A comprehensive range of measures are outlined below. Some measures are in the process of being implemented or developed, whilst other will require additional resource to implement:

All diagnostic modalities:

- Review social distancing and scanner throughput in line with pandemic recommendations in order to increase capacity back to pre-COVID-19 levels as soon as possible.
- Review of waiting lists and return some Cat 4 patients to referrer to review timeline for repeat/follow scan or if this request is still required. This is being carefully considered and will be thoroughly discussed and agreement reached across primary and acute care prior to any implementation
- Additional GJNH capacity

MRI

- Additional MRI sessions on NHSGGC sites is required
- 2 additional MRI scanners fully staffed (at GRI and QEUH) funded by the Scottish Government in place

CT

- Additional CT sessions on NHSGGC sites is required
- Additional scanner capacity at weekends on GGH and INS via staff working additional shifts is required
- Access to CT capacity at NHS Louisa Jordan is required

US

- Additional sessions from registrars and sonographers is required
- Use of NHS Louisa Jordan for AAA screening services being developed
- Clinical Decision Software to support referrals from Primary Care

To further support the recovery programme the service has recently been successful in recruiting 35 newly qualified Band 5 radiography staff across NHSGGC filling existing vacancies. Support arrangements are being put in place to facilitate these new staff are able to complete the appropriate competencies to enable them to join the 24/7 rotas as soon as practicable.

5.6. *Cancer, Inpatients and Daycases*

Cancer

Current 31/62 Day Cancer Performance

During COVID-19, NHSGGC has strived to maintain as much of our cancer services as possible. There has been very little impact from COVID-19 on chemotherapy and radiotherapy services and all urgent (category 1a/1b) cancer surgery patients were

operated on within 72 hours at all times. In most cases, NHSGGC has also ensured all category 2 patients (treatment <4 weeks) were treated within the appropriate timescale. Cancer imaging services were maintained during COVID-19.

During COVID-19 NHSGGC performance has been above trajectory against the 95% 31-day standard, with performance against the 62-day standard remaining static at 82%, 79% and 80% for March, April and May 2020 respectively. The main challenge faced by NHSGGC now is to date all outstanding category 3 surgical patients, particularly within the Urology tumour group.

Trajectory for 31/62 Day Cancer Performance
The table below shows NHSGGCs planned trajectory for cancer performance through to quarter 4 in 2020/21.

Cancer Waiting Times		**Mar-20**	**Jun-20**	**Sep-20**	**Dec-20**	**Mar-21**
% of patients waiting less than 31 days from decision to treat to first cancer treatment.	Pre-COVID-19 Trajectory agreed as part of the 2020-21 Annual Operational Plan	95%	95%	95%	95%	95%
	31 Day Revised Expected Trajectory	95%	95%	95%	95%	95%
% of patients waiting less than 62 days from receipt of an urgent referral with a suspicion of cancer to first cancer treatment.	Pre-COVID-19 Trajectory agreed as part of the 2020-21 Annual Operational Plan	90%	90%	90%	92%	95%
	62 Day Revised Expected Trajectory	80%	80%	80%	82%	85%

The revised trajectory for 31/62 day performance takes into account patients who have had/will have their cancer treatment delayed (on grounds of clinical prioritisation) as well as those who have been offered/will be offered alternative therapies as their first definitive treatment.

USOC Referral Rates
USOC referral rates within NHSGGC are in keeping with those elsewhere nationally. We have seen USOC referral rates recover to circa 60% of our pre-COVID-19 referral rate. Whilst referral rates for some tumour groups have fully recovered (e.g. Breast), others have not. Of greatest concern is the position of Lung USOC referrals which has not increased back to pre-COVID-19 levels. This is a national issue and there has been much work done nationally and locally to look at the position and encourage USOC referrals for Lung.

Cancer Surgery Prioritisation
The table below shows NHSGGC's current position in relation to waits for cancer surgery as of 24/07/2020.

Category	Awaiting Surgery (booked)	Awaiting Surgery (unbooked)	Target booking date for longest wait (unbooked)
1a/1b (<72 hours)	0	0	n/a
2 (<4 weeks)	37	33	14/07/2020 (waiting for RALP)
3 (< 3 months)	11	44	03/03/2020 (waiting for RALP)
New patients not yet prioritised by MDT	16	24	Prioritisation required by MDT
Total	**64**	**101**	

It is important to note that the information above is dynamic with new patients being added to the waiting list for surgery, and others being removed post treatment, at all times. There has been good turnover of patients within both Category 2 and 3 groups and with the exception of patients waiting for Robotic Assisted Laparoscopic Prostatectomies (RALP), patients are currently being dated within their respective timelines. Further information is provided below regarding RALP. Increasing theatre capacity for cancer services will be crucial and plans to address this are covered below. Urgent gynaecology oncology surgery has been reprioritised and supported through cross specialty working.

Urology/RALP Surgical Capacity
The single largest group of patients awaiting surgery are waiting for RALP procedures. NHSGGC is the tertiary service in the West of Scotland for RALP. During 2019 NHSGGC performed an average of 4 RALP cases/week.

Through trajectory modelling, the data shows that approximately 5 patients per week are being added to the waiting list. This has been lower throughout the pandemic period as diagnostic pathways have been disrupted. Therefore, the service needs to deliver at a higher volume than 2019/20 in order to address anticipated demand. Since the restart of the robotic programme, the service has averaged 5 patients per week for surgery. The robotic theatre is running for the full 10 sessions Monday – Friday and the team is working flexibly to ensure that all sessions are covered. However, with current PPE restrictions, the service is unable to schedule two patients per day and this is impacting on overall throughput.

In order to meet the current backlog of RALP cases NHSGGC has plans in place to deliver 7 cases/week in the first instance through longer weekday operating sessions and a fortnightly weekend session. Further planning is taking place to deliver a weekly weekend session which would allow for 8 cases/week to take place. The Board expects that it will take between 8-15 weeks to clear the current backlog of RALP cases depending on theatre throughput of between 7-8 cases/week. Given the particular impact of COVID-19 on NHSGGC, the Board is also engaging with other tertiary urology centres in line with national recovery/prioritisation planning for cancer services.

Systemic Anti-Cancer Therapy (SACT)
Demand for SACT services fell sharply with lockdown towards the end of March 2020. There has been a gradual rise in demand over the last 2 months as restrictions start to ease although we are not yet at pre-COVID-19 levels of demand. In addition to considering the SACT regimens most likely to benefit patients, alterations in the physical

delivery environment will be necessary in order to maintain safety in the post COVID-19 era.

The National Cancer Medicines Advisory Group (NCMAG) was established during the COVID-19 pandemic in order to provide a governance framework around the changes thought potentially beneficial in the prescription of SACT. Collaboration was sought between the 3 National Cancer Networks to coordinate a national approach to decision making and to support planning services in the event of disruption caused by the pandemic.

The remit of NCMAG is to engage with tumour site specific teams to consider proposed changes to clinical practice and to coordinate decision making on interim prescribing protocols and guidelines. In addition the group will seek to minimise risk to patients and optimise use of the national workforce. The group will only consider SACT within its licenced guidelines and any unlicensed medicines requests will continue to be evaluated by the parent Health Board in the usual way. The group is accountable to the Scottish Government National Cancer Recovery Group.

Inpatients and Daycases

Current Waiting List:
As at 20 July 2020 there are 25,219 (adults and paediatrics) on the inpatient waiting list; of these 20,288 patients have been waiting over 12 weeks. A number of patients have been waiting lengthy periods to be seen with 3,030 adults and 1,502 paediatrics waiting over 40 weeks; of these 1,082 adults and 759 paediatrics have been waiting more than 52 weeks.

Orthopaedics, Paediatric ENT, General Surgery, Surgical Paediatrics and Urology are the 5 specialties with the highest volume of patients waiting over 40 weeks as at 20 July 2020.

The typical conversion rate from outpatient appointment to IPWL differs across specialties but is generally around 30%. There are no indications at present that this conversion rate will change. Initiatives such as the EQUIP programme described in section 5.3 above can be expected to change patient pathways but impact on the IPWL is expected to be limited over the period of this plan.

The greatest influence on the inpatient waiting times is recovering base capacity within theatres. In July 2020 some aspects of staffing and services are still working outside their normal patterns, as such theatres across NHSGGC have been able to provide just 50% of base sessions thus far. Elective theatre sessions are directed towards priority 1 and 2 cancer and urgent patients. It is anticipated that 60% of 2019/20 activity can be undertaken by October 2020.

Furthermore the requirement for testing and isolation of patients ahead of any surgery brings added complexity to the current picture. The need to optimise pre-op management becomes even more important ensuring patients are well prepared for surgery and have all the information they need to avoid any potential cancellation. Each Sector has been requested to review local arrangements for pre-op management and look to strengthen pre-admission management through high risk clinical assessment. A Sector approach to testing with additional resource will ensure that previous levels of activity can be achieved from base staffing.

Re-establishing theatre services has presented challenges related to staffing with theatre groups underpinning the critical care response, separate patient streams for emergency and elective management, infection control restrictions together with a need to respond to a changing position for trauma and emergency activity and environment limitations related to COVID-19 from a hospital site perspective.

Teams are collaborating across NHSGGC to provide mutual support for solutions that will increase this capacity. Although sites have recovered to a level with all theatre suites active, the expectation is that theatre services can work to accelerate improvement in sessional delivery as constraints are overcome. It is recognised that the routine winter impact on elective activity will then be a consideration.

Finally, within the context of recovery NHSGGC is managing the major redevelopments for the Major Trauma Network and there are other developments coming through 2020/21 with the management of Mesh patients.

Plans for Increasing Inpatient and Daycase Capacity:
As noted previously some factors to increase capacity will be beyond the influence of NHSGGC, however the lifting of restrictions on shielding allowing staff to return to the workplace in early August 2020 will improve capacity. However, building on the progress to date, NHSGGC is currently developing plans to recover additional capacity.

As with outpatients, projecting the inpatient waiting list is reliant on accurate estimations of both inpatient/daycase admissions and additions to the waiting list. A number of different scenarios have been modelled to inform our plan. In addition specific detailed modelling has been carried out for Cancer. The table below shows what we expect the surgical patient demand to be each week across the different specialties.

	ESTIMATED FUTURE DEMAND
	NEW USOC REFERRALS
	Estimated No. Patients for surgery / wk
Breast	17
Colorectal	9
Gynae	3
Head & Neck	4
Skin	12
Upper GI	1
Urology - Bladder	4
Urology - Prostate	4
Urology - Renal	4
Total	**58**

NHSGGC has set out a wide range of actions to help treat patients and manage waiting times. These include:

- Allocate theatre lists for priority cancer care
- Undertake clinical validation of waiting lists to ensure priority patient management and confirm patient readiness for operative management
- Re-profile hospital sites to achieve as robust green pathways as possible and increase planned productivity

- Increase daycase management of patients
- Enhance staffing arrangements:
    - Maximally recruit to theatre nurse staffing posts
    - Proleptically recruit to anaesthetic appointments
    - Review specialty medical recruitment to limit operative gaps including consideration of Flying Finish
    - Increase base provision for multi-surgeon required operating for complex cancer delivery
- Ensure appropriate theatre equipment and instrumentation provision to support increased activity
- Continue to adapt and enhance pre-op assessment and pre- admission management to reduce cancellations
- Use external capacity: utilise available capacity for specialty specific care in Independent sector and GJNH as directed through the Scottish Government
- New approaches: senior medical review of new / alternative operative approaches to achieve increased activity and modernised approach to patient management with appropriate technology
- Run additional sessions:
    - Optimise the potential for additional sessions through increase of base sessions where physical theatre capacity is available
    - Establish weekend working on chosen sites to generate targeted additional capacity encompassing specific cancer activity
    - Exploring insourcing provision
- Accelerate staff training to support new ways of working and reduce reliance on junior doctor staffing
- Level 1 ERAS nursing provision on inpatient sites to ensure HDU capacity is not limited by delayed transfer of care to the wards
- Cross Sector specialty working
- Review specialty capacity plan
- Coordinate working with WOS Boards

It is important to link plans for extending inpatient and daycase planned care with the available surgical bed capacity. Current Board plans are reliant on maintaining current levels and do not envisage increases in surgical activity that demand a greater bed base. There may be a requirement to use bed capacity in alternative configurations to optimise theatre resource. The usual reduction on elective occupancy of surgical beds can be expected for a short period over the peak winter period and during any sharp increases for trauma activity.

Allocation of theatre lists for priority cancer and urgent care

The Post COVID-19 period has required careful allocation of theatre resource at a site level to balance specialty urgent demands. No site has returned to pre COVID-19 theatre schedules and continued flexibility is required to ensure sessions can be provided for patients identified through cancer MDTs together with specialty identified urgent patients.

Particular challenges relating to Robotic surgery requires alternative capacity for priority 2 benign surgical patients based on the modelling of anticipated RALP patients requiring surgery. Additional capacity from GJNH will be sought for displaced activity to achieve maximum capacity for robotic surgery.

Clinical Validation and Re-prioritisation of Waiting Lists
In order to ensure patients with the highest priority for treatment continue to be seen, clinical teams across NHSGGGC have been reviewing their waiting lists in line with national prioritisation guidelines. Clinical validation to date has been undertaken and will be re-visited.

In order to improve consistency of approach we are setting out clear expectations for clinical prioritisation based on the Royal College of Surgery guidelines and the National Cancer Framework. Where national guidelines are not available we will use cross Sector specialty group meetings to agree a set of local guidelines supported by work with the local Clinical Effectiveness team. Clinical Directors and Clinical Leads will be key to ensuring consistency of approach. Clear timescales will be given taking into account this process will take longer in specialties where there are high numbers of patients waiting. Resource will be directed at long waiting patients to re-triage and make sure that procedures/appointments are still necessary and that patients are fit to proceed to surgery.

This clinical revalidation review process will be embedded within all services with patients re-prioritised as appropriate to better understand the profile of the waiting list. In addition to this, a separate administrative review of longest waiting patients is underway.

Re-Profiling of Sites
Given the number and range of hospitals across the NHS Board area, NHSGGC has the opportunity to exploit the potential of different sites and create protected elective capacity to assist recovery. This will also provide a degree of protection during any future surge of COVID-19, subject to demand for critical care.

Options for use of existing infrastructure are currently being worked through but will follow the assumptions and principles set out in this plan. It is likely that proposals will be defined around the following patient groups:

a) Intermediate cancer surgery - laparoscopic colonic surgery, intermediate gynaecological surgery, endo-urology
b) Benign general surgery/urology/gynaecology
c) Orthopaedic surgery including arthroplasty
d) Minor surgery including local anaesthetic and daycase surgery
e) Ophthalmology

Re-profiling of sites may require a redesign for some services. NHSGGC recognises this may require significant transformational change and will commit to Executive level support to enabling this change.

Additional resource to manage the patient acuity, ensure take back facility and new working arrangements will be required in some locations. However this option is being considered in order to maximise the potential of our available sites and address the waiting times challenge.

Increase Daycase Management of Patients
The re-profiling of sites provides NHSGGC with a great opportunity to expand the approach to day surgery. Working across a range of specialties we will seek to optimise day surgery and aim to move the threshold for day surgery.

Enhance Staffing Arrangements
Theatre teams in particular have been at the forefront of supporting the COVID-19 pandemic, with many redeployed to our critical care environments and in a number of areas there are still support arrangements in place meaning theatre teams are not yet back to full capacity.

There are a number of options to be explored to maximise the staffing. This will include recruitment into weekend working or extended operating days, use of WLIs, supplementing the base capacity for additional sessions, minimise the impact of known/predicted vacancies or planned leave arrangements (maternity leave) by maximally recruiting to theatre nurse staffing posts and using proleptic appointments to recruit to anaesthetic posts. Furthermore there will be a review of specialty medical recruitment to limit operative gaps, including consideration of Flying Finish. These actions will be dependent on the level of resource available.

Additional resource for training will be essential; for example, training for anaesthetic and scrub nursing roles (including advanced scrub noted in the staff training section below), training for Band 4 theatre roles successfully deployed nationally to increase the level of session availability, and support for pre-habilitation. The resource implications of all these approaches are currently being worked through.

In addition there is opportunity to review and with appropriate resource identified to extend ERAS and ward based level 1 support with a view to reducing length of inpatient stay and prevent delayed discharge from HDU.

During the peak COVID-19 period medical staff in particular supported patient care with flexible working approaches. This will continue to be required as we move through the elective recovery programme and ensure that skilled staff can be directed to elective management. Some increase in base provision for multi-surgeon operating may be required for complex cancer delivery.

Equipment provision
A full assessment of theatre instrumentation will be taken forward to identify any areas of particular concern. This will be particularly important to ensure changes to the profile of activity in sites is supported with appropriate equipment. For example, in some situations laparoscopic procedures can provide opportunity for more efficient working practices and minimising inpatient stays. Recent assessment indicated there are limitations in the availability of laparoscopic equipment across some sites in NHSGGC and additional investment in equipment would be of benefit and will be assessed.

Pre-op Assessment
COVID-19 considerations make effective and efficient pre-operative assessment even more critical to ensure cancellation of surgery is avoided, particularly late cancellations.

All Sectors are in the process of reviewing how they deliver pre-op assessment; this will include exploring options to increase virtual management where appropriate.

High risk anaesthetic clinical assessment is being reviewed for potential expansion to ensure patients are optimised for their operative intervention.

Pre-admission management, adopting ERAS approach to care will be a key focus.

Use of External Capacity – GJNH, Private Sector and Other Options
NHSGGC is keen to secure additional capacity to assist in the recovery of elective waiting times. Sessions have been secured with the GJNH and the Nuffield Hospital and discussions will continue to ensure NHSGGC can maximise the opportunities this capacity brings. NHSGGC will work collaboratively over the coming months to ensure there is appropriate use of available capacity across the West of Scotland Boards and the additional resource to support this. However the current provision is significantly less than is required to target a reduction of waiting lists.

The delivery of base theatre sessions will remain focussed on cancer and urgent requirements. Additional external capacity will be key to generating green streams for patients.

The option of utilising space in other WOS NHS Boards has been the subject of discussion at the Acute Care Network meeting and at the Regional Planning Group meeting.

The current Service Level Agreement (SLA) process is essentially suspended at present and at this stage future activity levels are still to be clarified.

At present NHSGGC has not included any level of private sector capacity, although it is anticipated that this will be required.

External Capacity at GJNH
The significant efforts of the GJNH to work with NHSGGC during the COVID-19 pandemic with the management of specialist MSK oncology, Plastics Sarcoma patients, orthopaedic revisional /palliative care and colorectal cancer surgery patients was an important contribution to the maintenance of cancer and urgent care .

It is recognised that the impact on the GJNH activity with prioritisation of cancer care for all West of Scotland Boards has meant that patients on the waiting list remain assigned to the Independent Sector and GJNH for care across a range of specialties.

The continued support of the GJNH team in 2020/21 is integral to the remobilisation of NHSGGC elective activity. It is assumed that the remaining patients from NHSGGC will be managed through the GJNH for Orthopaedics and Ophthalmology.

The base SLA activity has been reflected below and forms the basis of the required support.

Specialty	**SLA level**
Endoscopy	1270
Orthopaedics	Joints 660 Foot & Ankle 170 Other 70
Ophthalmology	3600
General Surgery	160

Discussions have been progressed with GJNH senior colleagues with regard to specialist care for Orthopaedic Spinal priority 2 patients to overcome the challenge of securing appropriate theatre capacity for this patient group within the Board. Support has also been requested to manage Immediate Breast Reconstruction (IBR) activity that at the present time has been difficult to accommodate given competing priorities for complex cancer care

patients. Continued support for general surgery/ colorectal activity with priority 2 patients in the first instance would be welcomed.

Critical to the recovery for Orthopaedic care is maximum provision at GJNH. In addition is the provision of Endoscopy activity where the limitations relating to COVID-19 infection control measures compromising the throughput is significant for all.

The following activity request is made for the period Sept 2020 to March 2021:

Specialty	SLA level	Comments
Endoscopy	2500	
Orthopaedics	Joints 660 F&A 170 Other 70	Additional activity to these proposed numbers across any of the subspecialty elements would be welcomed
Orthopaedic Spinal	Non SLA - 250	
Ophthalmology	4500	
General Surgery	350	To include Immediate Breast Reconstruction

In the recovery phase the sessions for the specialist activity and more recently for core Endoscopy activity has been covered through the transfer of NHSGGC operators delivering sessions at the GJNH. It is not anticipated that the above activity would be delivered utilising core NHSGGC operator sessions with the exception of Immediate Breast Reconstruction and Spinal activity.

New Approaches

A number of new techniques are described in the Endoscopy section but there are other potential areas of development including LA hernia repair, uni-compartmental knees via day surgery and Total Hip Replacement via day surgery. In addition alternative approaches to anaesthetics are being considered where appropriate, for example use of nerve blocks. New technologies at specialty level including laser surgery will be examined.

Within Urology, extending access to Lithotripsy was agreed in principle by West of Scotland Boards prior to the COVID-19 pandemic recognising that prompt access to Lithotripsy will reduce emergency admissions and surgical interventions for stones patients. However agreement on final proposals was paused in March 2020. Discussions have re-commenced and will aim to be concluded as soon as possible.

Additional Sessions

As in outpatient services, additional theatre sessions could be provided in addition to base capacity to manage the significant backlog in patients waiting. Typically these additional sessions are provided by staff taking on additional hours at evenings and weekends to hold waiting list initiatives (WLIs).

Weekend working in targeted sites with the appropriate resources is likely to be necessary. Options for stabilising commitments to this would be beneficial and options under the Flying Finish banner will be explored. Proposals are being developed for site based support generating cover for additional capacity for operative work together with additional diagnostic activity.

In previous years WLIs, and also insourcing options, have been used with additional resource to help manage waiting times and this would be an area NHSGGC would seek to explore in 2020/21.

Insourcing provision used in previous years will again be considered.

Accelerate Staff Training

In order to make best use of resources, we require our staff to have the range of skills that enables maximum flexibility of approach to delivering services. An example of this is dual trained staff in anaesthetic nursing support and scrub techniques. The Golden Jubilee National Hospital has plans to develop a skills academy which may provide opportunity for our staff in the future, however expanding established internal training plans would bring the added benefit of retention of staff. Investment in Advanced Scrub roles fits well with the Adept programme of advanced nursing practitioners. To increase base session activity in the longer term additional Advanced Scrub nurse posts would provide flexibility regarding the type of activity that could be covered in sessions. As noted in the enhanced staffing section above, training is also required for the Band 4 theatre roles.

NHSGGC has experience in using staff in extended roles and will continue to explore options identified immediately pre-COVID-19; for example in orthopaedic pathways with Podiatry supporting foot surgery.

Level 1 ERAS Nursing

NHSGGC has a well established ERAS approach to patient management across various specialties. Enhancing level 1 nursing on our surgical wards would have the benefit of reducing patient length of stay in HDU and overall length of stay in hospital. This would take some time to establish and additional investment but could be an important support to balancing surgical bed capacity and maintaining the elective programme during winter 2020/21.

Cross Sector Specialty Working

During the COVID-19 response specialties and services have noted significant improvements in cross-system working; for example MDTs and group case conferences, and realignment of services to allow more one-stop visits for patients. The initial phases of elective surgery recovery has seen cross Sector sharing of cases and cross specialty working to ensure patients can be seen as soon as possible, for example Urology cancer patients.

As theatre capacity increases and routine surgery is re-started there will be the potential to offer capacity more on a Board-wide basis to ensure equal access. This will require a coordinated approach across Sectors and will be addressed through strengthening cross Sector specialty meetings and encouraging collaboration to meet the needs of our patients.

Specialty Capacity Plan Reviews

The review of the specialty capacity plans will outline the available capacity for inpatient and daycase activity.

Furthermore the new anaesthetic rostering tool that is planned for use from late 2020 will provide greater flexibility with anaesthetic capacity.

Combined these two tools will help to identify further opportunities to coordinate services to better match demand and redesign activity where this is indicated. It is also likely this approach will identify longer term investment requirements in some specialties to address capacity gaps.

Coordinated Working with West of Scotland Boards
The COVID-19 pandemic identified opportunity in some specific specialty pathways to re-think the way NHSGC works with other West of Scotland Boards. There is potential to continue this hub and spoke type approach and work across the region to deliver support in a different way to help West of Scotland Boards to manage their patient pathway. This will be explored over the coming months in conjunction with West of Scotland Regional Planning.

A mutual aid protocol has been agreed across NHS Boards in Scotland ensuring that cancer surgery is managed across Scotland to the benefit of all patients.

Orthopaedic Recovery for Long Waiting Patients
NHSGGC recognises the duty to all patients waiting for services. Urgent care has always been prioritised, this remains unchanged. Nevertheless Orthopaedic patient demand has a profile unmatched by any other service.

Clinical prioritisation of patients is vital and there requires to be a balanced approach to having extended waits for patients where deterioration of their condition may not be life threatening, however recognising this may lead to increased risk of development of associated conditions or significant reduction in quality of life. This is particularly so in Orthopaedics where the demographics reflect the aging population. The current Orthopaedic outpatient and inpatient waiting list position reflects this situation and is shown in the tables below:

Outpatient Consultant Waiting	**Total No. of Patients**
Total	*6700*
Non Consultant Outpatient Waiting	**Total No. of Patients**
Total	*6748*

Inpatient Consultant Waiting	**Total No. of Patients**
Total	*8427*

Addressing the Orthopaedic Challenge:
The delivery of reorganised trauma configuration within South and Clyde Sectors to support the Major Trauma Centre (MTC) is a priority for the NHS Board within the timescale of this plan. Whilst this will enhance the arrangements for trauma care we need to ensure focus continues on elective recovery throughout the MTC implementation process.

Nationally and locally there has been progress in Orthopaedic care through the national modernising outpatient agenda, local Access Collaborative support and cross Sector review of efficiency. Key enablers identified from these work streams to deliver sustained improvement include:

- Streamlining trauma and elective activity
- Enhanced support to achieve increased daycase rates
- Review of core medical staffing
- Increasing AHP and ANP staff
- Remodelling spinal service
- Full adoption of ACRT and PIR
- Increased theatre capacity
- Review and enhance Laminar Flow capacity/utilisation
- Enabling works to enhance patient pathways
- Team based working / MDT management of complex care
- Combined waiting list management at subspecialty level
- Ortho specific review relating to site re-profiling
- Increased access to GJNH

To maximise potential the approach to day surgery within Orthopaedics will be re-invigorated. Enablers to achieve this will include some duplication of equipment, support post operatively through nursing teams to ensure effective patient management and admission avoidance. Generating volume green hospital sites for this activity will require further recruitment of specialist Orthopaedic theatre staffing and dedicated anaesthetic management for the use of block analgesia.

Long Waiting Patients – All Specialties
The longest waiting patients for clinical services are limited by either patient volume such as those in Orthopaedics or for highly specialist care where there are few practitioners with the specialist skills, knowledge and experience to see the patients; for example in Urology for female reconstruction surgery. There is no doubt that clinical prioritisation remains the guiding principle for recovery, nevertheless there is a need to ensure that this patient group are not additionally disadvantaged.

A systematic senior clinical review of longest waiting patients and the potential for capacity will be reviewed directly within NHSGGC Access meetings to ensure cross sector commitment to managing a staged reduction in this patient group. Available capacity internally and externally will be identified to ensure a constructive clinical discussion can direct appropriate balance of allocated space for the longest waiting patients that will not interfere with cancer and urgent patient management.

Maximising Productivity
As with outpatient clinics, use of inpatient and daycase capacity will be closely monitored by service teams to ensure use of sessions is maximised. Teams have a mix of daily and weekly meetings to coordinate activity. Current weekly performance monitoring will be enhanced to ensure a rigorous process. Chiefs of Medicine, Clinical Directors and operational management will work with their clinical teams to ensure that late cancellation of sessions is avoided wherever possible, and where lists become available the list is allocated to another clinician or made available for use as a cross Sector list

5.7. *Hospital Paediatrics*

COVID-19 has not had a significant prevalence in children as previously documented, however if this were to change in future spikes then surge capacity is built into our scenario planning and pathways for managing the disease.

Patient Safety
Our agreed red and green pathways in place across Emergency Department, Ambulatory, Paediatric Intensive Care, Theatres and Outpatients follow national guidance for maximising patient and staff safety. Where there has been any deviation because of specific needs of children and families we have followed an appropriate Board authorisation process with full involvement from Local Infection Prevention and Control (IPC) and Health Protection Scotland (HPS) as appropriate.

Screening and Testing
Paediatric and neonatal services continue to comply with COVID-19 screening and testing policies. All our staff working in haematology oncology services are being routinely tested weekly. All patients attending for surgery are tested 72 hrs before their procedure.

Patient Centred Care
A focus on delivering patient centred care during COVID-19 has been a priority. Examples of where we have worked to maintain this is in parent access to being with their child while undergoing treatment. We have also been sensitive to the needs of children and young people when wearing various layers of PPE and masks / visors. All our signage linked to COVID-19 instruction has been sensitive to the needs of children and families.

Recovery
All re-mobilisation plans allow for maintaining of social distancing. The impact of this in respect of capacity plans for assessment and treatment of planned/ non-scheduled patients is under review. Focus on planned care is on increasing the number of routine theatre lists running, and patients being processed per theatre list.

There has been no deterioration in our unscheduled care performance during the COVID-19 period, with some slight improvement whilst numbers presenting have been low. We have maintained throughout this period, a robust emergency/ trauma surgery capacity, and also focus on maintaining paediatric Cardiac Surgery and Neurosurgery programmes. We continued to provide emergency Renal Transplant programme throughout COVID-19 period and have now re-instated our living donor programme.

5.8. *Maternity*

Maternity services continue to provide safe care for all pregnant women. The service has ensured the safe provision and adequate staffing at three Maternity Units to support births however services were temporarily ceased at the CMUs at RAH, IRH and VoL and home births were also temporarily suspended.

Plans for Recovery:
Actions for recovery include:

- The Home Birth Service in Greater Glasgow will recommence in all areas by end July 2020.
- Reopening of Community Maternity Units (CMUs) and midwife led birthing options by end August 2020
- Reinstated full access to birthing pools
- Reinstated Early Pregnancy Assessment Service (EPAS) to original locations
- Home Blood Pressure Monitoring being rolled out. Midwives will use telephone consultation to check BP readings. The 2nd stage of the home BP monitoring will involve more Near Me consultant appointments.
- Reinstatement of Gestational Diabetes Mellitus (GDM) screening and plan to use Near Me as appropriate. Already in use for specialist obstetric diabetic clinics.
- Increase throughput of Obstetric Ultrasound including repeat FAS, growth scans
- Increase Access to Antenatal Clinic appointments with appropriate social distancing measures amalgamating remote spokes
- Reinstating antenatal steroid cover.
- Generic mailboxes have been set up for all sites so that community midwives can email consultants for advice on specific patients avoiding unnecessary consultant appointments. This is working extremely well and will continue.
- Parentcraft has been held in groups and before COVID-19 different methods were being explored. Virtual methods introduced and will be maintained.

Key Points
• **Increasing outpatient capacity to 80% of 2019/20 rates by December 2020 by expanding use of virtual patient management, extending the EQUIP programme, clinical validation and reprioritisation of waiting lists and using group management of patients as appropriate** • **Increasing endoscopy capacity, by reviewing site arrangements, enhancing staffing and using external capacity** • **Increasing radiology activity by recruiting 35 replacement radiography staff, and modelling scenarios with differing levels of input and resource to address the backlog** • **Prioritising treatment of all category 3 cancer surgical patients, particularly targeting the urology tumour group** • **Increasing inpatient capacity by clinically validating waiting lists, increasing day management of patients, enhancing staffing arrangements, enhancing pre-op assessment and pre-admission management, running additional sessions and utilising external capacity. It is planned to increase to 60% of 2019/20 rates by October 2020.** • **Recommencing of the full home birth service in all areas by the end of July and reopening of all Community Midwifery Units by end of August** • **Maintaining surge capacity in paediatrics to cope with COVID-19 spikes and winter**

6. Acute bed capacity

The demand for beds will come from the following sources:

- Patients with COVID-19
- Emergency Admissions
- Urgent / USOC admissions
- Elective admissions

6.1. *COVID-19 Bed Projection*

There is a degree of uncertainty in how the COVID-19 epidemic in NHSGGC will evolve over the winter months of 20/21. No national modelling data is available as yet.

However, the Academy of Medical Sciences (AofMS) document Preparing for a Challenging Winter 2020/21 suggests that if the R0 remains low (R0 1.1), then there is unlikely to be an obvious second peak over the winter months. Therefore, in this model COVID-19 would have minimal impact on health service demand, over and above our typical winter demand.

If from September 2020 the R0 increases to 1.5, they estimate a second peak of COVID-19 cases, admissions (including ICU), and deaths occurring in January / February 2021. The median of this peak is estimated to be ~ 2/3 the size of the first peak experienced in April / May 2020. However, if R0 increases to 1.7 from September 2020, infections would be expected to rise gradually over the autumn and winter months with a peak in hospital admissions and deaths of a similar magnitude to the first wave, again in January / February 2021.

The AofMS modelling assumes a number of things: that transmissions will follow a similar pattern to the first wave, that the estimated R0 in September 2020 remains the same throughout the time period being modelled, and that COVID-19 transmission will be influenced by similar climatic conditions as other respiratory tract infections.

However, not included and less certain, is the potential impact of local outbreaks or spikes, the degree to which immunity is conferred by past infection, potential interactions between other respiratory viruses and COVID-19, mutational change of the virus, level of adherence to population based mitigations, adverse impact of lockdown on general health, and the pattern of transmission in particular groups and settings.

Estimates of peak demand expected in January / February 2021 can be provided by applying the model, provided by AofMS, to the actual NHSGGC data on bed occupancy in hospitals and ICU.

The number of patients in hospital will be in both acute and mental health beds – there have been 50 patients in mental health beds since April 2020.

	Hospital Bed Occupancy (Jan / Feb 2021)	**ICU Bed Occupancy peak (Jan / Feb 2021)**
Scenario 1 R0 = (as at 24 July)	174	2
Scenario 2 R0 = 1.1	404	49
Scenario 3 R0 = 1.7	608	74

Intensive Care Beds
GGC opened an additional 55 ICU beds from is base complement of 45 in order to create capacity for the impact of COVID-19. At peak 86 beds were occupied – 75 of which were patients with COVID-19.

During the winter there will be additional demand for ICU for patients with flu and other exacerbations of acute illness with the likelihood that doubling ICU capacity would be required for scenario 2 and tripling for scenario 3.

Plans remain in place to double capacity within a week and triple within two weeks. Sufficient ventilators and other equipment is in place to double ICU capacity – tripling would require use of anaesthetic machines or additional ventilators from national stock. This will require the cancellation of theatre activity to free anaesthetic, medical and nursing staff to support additional beds.

Workforce plans are in place to ensure that staff with suitable skills not currently working in ICU retain those skills and additional staff are being trained in ICU skills in preparation for this winter.

If expansion of ICU beds is required the transfer team established in the first phase will be re-established to ensure equity of access for patients and make best use of all available resource

Scenarios	**Beds**
Adult ICU Base Beds	45
Adult ICU Double Bed Capacity	90
Adult ICU Triple Bed Capacity	135

6.2. *Emergency Admissions*

An increased level of emergency admission can be expected over the winter and an increased length of stay due to the impact of winter on those with underlying health conditions.

With the current phase of “shielding” coming to an end on 31st July 2020 there will be a reduced need for the provision of protective isolation and this will increase the flexibility hospitals have for admission capacity. However, plans will remain in place to respond to any future changes in guidance.

Patients with respiratory illness are at high risk of emergency admission and infection from flu and COVID-19. It is the intention to continue the Respiratory Response Team will provide specialist input to the care of patients with COPD who are high risk of requiring emergency admission during the winter. This service was created to provide a safe alternative to hospital admission for the chronic lung disease population with the awareness of nosocomial inpatient spread and potential poor outcomes for those with severe lung disease. The team provides a single point of access for patients and GPs and offers specialist support to care homes. The team is multidisciplinary with daily Consultant support and works across primary, community and secondary care. The provision of oxygen to care homes also assists with keeping people in their own homes particularly at the end of life.

A major focus for NHSGGC has been the introduction of Anticipatory Care Plans in conjunction with patients, their families and carers where appropriate. This work pre-dated the COVID-19 pandemic and will continue to be embedded across NHSGGC

The Board is participating in the DYNAMIC-COPD project with DHI offering remote management, asynchronous messaging, and anticipatory care planning. High risk patients have been identified and invited to take part. The Board is also participating in the Virtual Patient Pathways project with potential to offer patients with heart failure this intervention and support them in their own homes.

Working with our partner Local Authorities a new discharge policy will be introduced delivering Discharge to assess model. This will ensure that no person who has been in hospital less than 7 days will have their social work assessment undertaken whilst they are in hospital. No patient will wait for support that should be provided in another setting and patient will safely move to a setting that meets their needs whilst any further assessment required is undertaken. HSCP teams will work closely with hospital teams with a single point of contact for referral and early identification of those people who might not require social work assessment.

This will generate additional inpatient capacity in acute hospitals by ensuring that people are discharged as soon as they are well enough.

In order to respond to the increased demand for COVID-19 and winter additional staff will be required in:

- ED and Assessment Units to ensure sufficient senior clinical decision makers are available at peak times during early evenings and weekends
- Inpatient Consultant capacity to deliver additional ward rounds at weekends
- Allied Health Professionals (AHP) capacity to expedite assessment, treatment and discharge planning
- Dedicated boarding teams, to ensure continuity of care and specialist input for patients who cannot be admitted to the appropriate speciality ward
- Extended Pharmacy hours into early evening and weekends
- Additional diagnostic support

Whilst the reduction in face to face appointments has generated additional Scottish Ambulance Service capacity provision will also be made for additional transport to support discharge from hospital.

Each hospital site has an agreed escalation plan to ensure that all available beds are used to ensure patients are admitted for planned or emergency treatment as promptly as possible. These plans have been reviewed during the pandemic and will be revised again as part of detailed planning for Winter 2020/21. The enhanced staffing described above will ensure that patients admitted to another area receive the required level of specialist care.

At peak it is anticipated an additional 174 beds will be needed for COVID, with another 80-100 beds being required for winter pressures. This assumes that elective treatment continues at the same rate as last winter with the usual reduction in January as planned.

A detailed capacity plan and workforce plan will be developed by September 2020 to ensure additional capacity is available when required and that best use is made of all inpatient beds.

Should a peak of COVID-19 occur the cancellation of elective treatments to support an increase in ICU beds would also free up capacity for these patients. At the first peak with 600 patients with COVID-19 in hospitals across NHS Greater Glasgow and Clyde there were over 1000 empty acute beds.

A reduction in elective treatment to only clinically urgent could free up 400 beds across NHSGGC acute hospital sites. However it is recognised that a flexible approach to utilising available resources across the Board, including ACH sites, will need to be considered to ensure cancer and urgent activity is maintained.

It can also be assumed that a peak in COVID-19 would reduce emergency presentations as in the first wave albeit to a lesser extent given the impact of other recurrent illness in winter.

7. Unscheduled Care

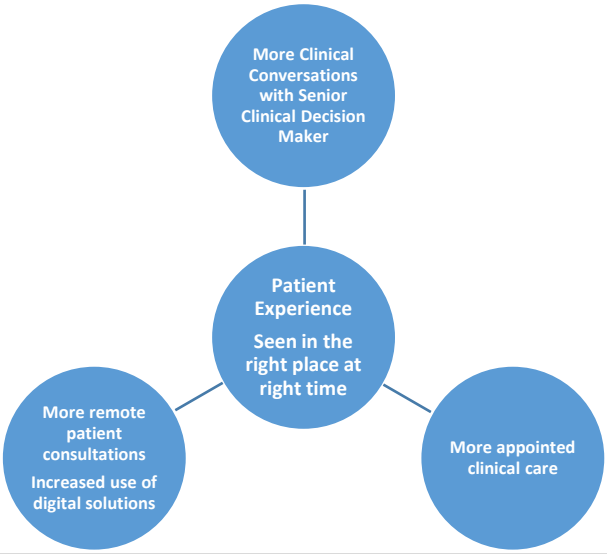
7.1. *Redesigning Urgent Care*

Our overarching aim is to ensure that patients who need urgent care get the right advice in the right place, delivered by the right clinician, minimising disruption and inconvenience for themselves, carers and families, and ultimately provide a better experience and outcome for the patient. The potential advantages of a more planned approach to unscheduled care attendance will be significant by reducing overcrowding and unnecessary face to face contact, and improving patient safety through physical distancing, as an important factor in reducing winter pressures and preventing the spread of the disease.

The direction for unscheduled care set by Scottish Government describes the need to redesign urgent and emergency care for people of all ages with physical and mental health conditions. The priority for NHS Greater Glasgow and Clyde is to achieve this by fundamentally shifting towards a model that sees the transition of unplanned care to one where services can deliver a planned urgent care response alongside an acute emergency access route. This, coupled with the ongoing need to manage the impact of COVID-19, will influence the future delivery model of unscheduled care across our Health and Care System.

Collaboration and consistency across the whole system, of primary and secondary care, will be key to delivering a model of planned urgent and emergency care that is responsive to the urgent physical and mental health needs of patient every day of the week. This will need to be underpinned by strong public messaging. On this basis, learning from the implementation of the planned care model for the GP out of Hours Service and the Community Assessment Centres introduced to provide a dedicated COVID-19 pathway will be applied to other elements of the pathways.

The need to ensure our patients are seen in the right place at the right time underpins the move to a system of more appointed clinical care as demonstrated in the diagram below. This will be supported by moving senior clinical decision makers to the start of the patient journey with an early clinical conversation providing triage/assessment prior to attendance, and enabling as much appointed care as possible in the emergency care environment.

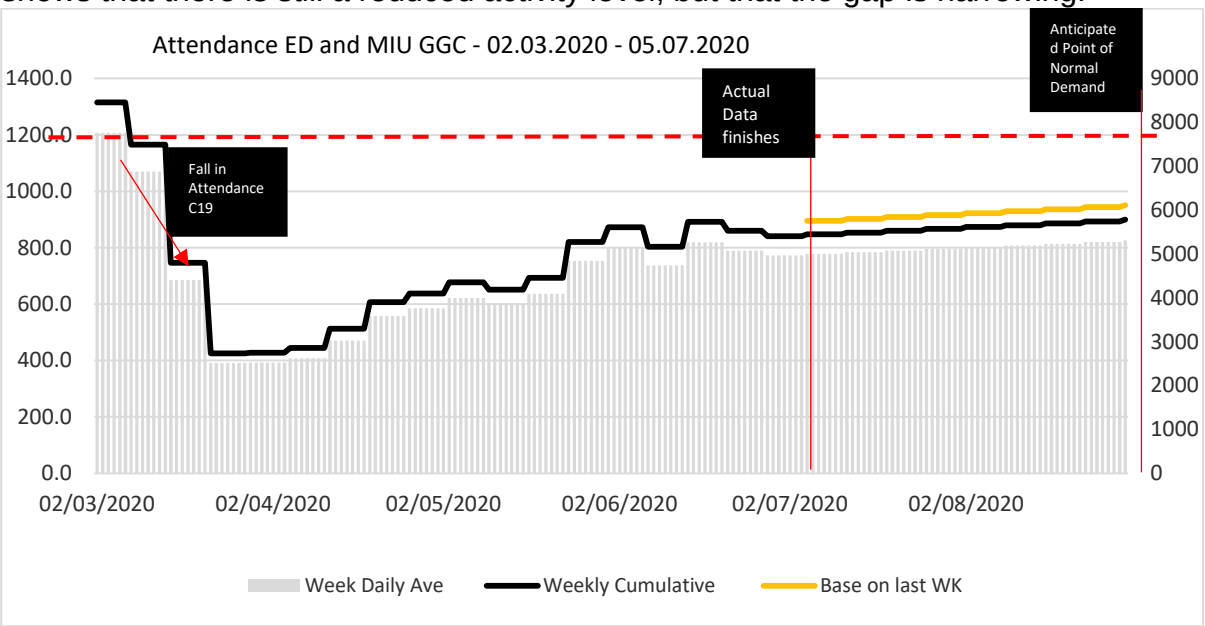


7.2. *Supporting GPs and Assessment Units*

To build on the learning from GP OOH service improvements and the implementation of CACs, our proposal is to create two clear routes to provide specialist advice to GPs for patients who require an urgent care response. SCI Gateway advice referrals to specific consultants should be made available for a 72 hour response, Consultant Connect will be made available for a more immediate response. If following specialist advice, the GP requires further assessment, the call will be transferred to the Assessment Unit Booking Line. At this stage, a 'Near Me' appointment could be planned or the patient could be directed to immediately attend the Assessment Unit. This avoids unnecessary delays for patients waiting in the AUs to be seen and will reduce congestion through the provision of both immediate access and an urgent planned care response with appointments requested and facilitated in real time giving assurance to GPs.

7.3. *Maintaining COVID-19 Pathways in Hospitals*

Since the height of the pandemic, when Emergency Department (ED) and Minor Injury Unit (MIU) attendances dropped significantly, activity has begun to increase. The graph below shows a weekly profile incorporating a 4 week rolling average projection. This shows that there is still a reduced activity level, but that the gap is narrowing.



The introduction of Specialist Assessment and Treatment Areas (SATAs) for patients with symptoms suggestive of COVID-19 form an essential component of the COVID-19 response. Departments have been reconfigured to accommodate SATAs and to ensure we have the ability to continue to deliver this pathway as well as manage the predicted increase in emergency attendances as the service returns to near normal levels.

Over recent weeks the number of GP Referrals to AUs has seen a steady increase. The SATAs will need to continue and they will be flexed to meet demand.

In order to maintain infection control precautions the red and green pathways described in the Board's earlier plans will remain in place supported by the provision of PPE. Maintaining these pathways through winter will require additional support as other areas of activity increase.

Point of care testing for COVID-19 and flu will be available in EDs, Assessment Units and SATAs and also in Intensive Care Units. This will allow a number of patients to be discharged directly without the need for admission once their diagnosis is clear and will also assist with ensuring patients can be isolated on admission should that be required. An agreed flu pathway will be in place across primary and secondary care including the GP OOHs service.

Whilst children were not greatly affected by COVID-19 it can be anticipated that there will be a greater impact during the winter with the impact of RSV. A clinical pathway will be in place across primary and secondary care to ensure that this demand can be safely managed.

Signposting is in place at all the adult Emergency Departments whereby an experienced nurse undertakes a short assessment and directs patients to Pharmacy, Dentist, Optometrist, GP, GP Out of Hours, Sandyford Centre, Minor Injury Units or NHS24, as appropriate.

7.4. *Factoring in Winter*

The impact of COVID-19 was first felt in March 2020. Prior to that the number of people attending ED had increased by 2% from the previous year and the number of GP referrals to assessment units by 5%. Pre COVID-19 emergency admissions to hospital between April 2019 and February 2020 had increased by 2.6 % compared to 2018/19.
In planning for this winter, November to March, it has been assumed that

- emergency ED attendances will remain less than last year due to the introduction of the SATAs and the new pathways described below
- emergency admissions will increase by 2% from last winter

A summary winter plan is attached in Appendix 1 and detailed numbers are in the template in Appendix 2.

7.5. *Maintaining COVID-19 Pathways in the Community*

The Community Assessment Centre (CAC) pathway was set up to provide a dedicated access route for patients with symptoms of COVID-19, to protect both patients and staff. Maintaining this pathway is key to General Practice recovery, maintaining COVID-19 free services to support patients including those with multiple complex needs and long term conditions including frailty. The pathway has four service elements:

- NHS 24
- GGC Resource Management Centre
- GP hub, for clinical conversation
- Community Assessment Centres for physical consultations

Although the number of CACs will reduce in line with reduced COVID-19 demand, the centres will be hibernated and the pathway will be retained to support winter planning. Over winter, demand and capacity surrounding respiratory and COVID-19 patients will be

monitored, with CACs being scaled up accordingly. They will see respiratory patients, including COVID-19, and will offer point of care flu testing. This will allow us to quickly respond to any increases in COVID-19 infection rates.

7.6. *Redesign of Unscheduled Care*

National work is progressing to develop a consistent pathway into urgent care for those who currently self-present at ED (50-60% of attendances across NHSGGC). Whilst GPs will continue to provide urgent care to patients in hours, access to EDs will be through an NHS 24 single point of access. Local Boards will subsequently offer rapid access to a senior clinical decision maker who will optimise digital health opportunities and signpost callers to available local services. This service will require local Boards to establish Flow/Navigation Centres, which will need to be in place by 31st October 2020. A national public marketing campaign will support this pathway redesign.

The ability to deliver the above changes is dependent on available resource as previously noted.

Key Points
• **Supporting GPs by offering a consistent range of electronic advice options as an alternative To admission to Assessment Units** • **Maintaining COVID-19 pathways in hospitals and communities to protect staff and patients** • **Continuing the service improvements to the GP out of hours service** • **Ongoing support for successful service changes implemented during COVID-19 e.g. signposting at EDs, SATAs and Community Assessment Centres** • **Developing the GGC response to the National work to increase scheduling of urgent care**

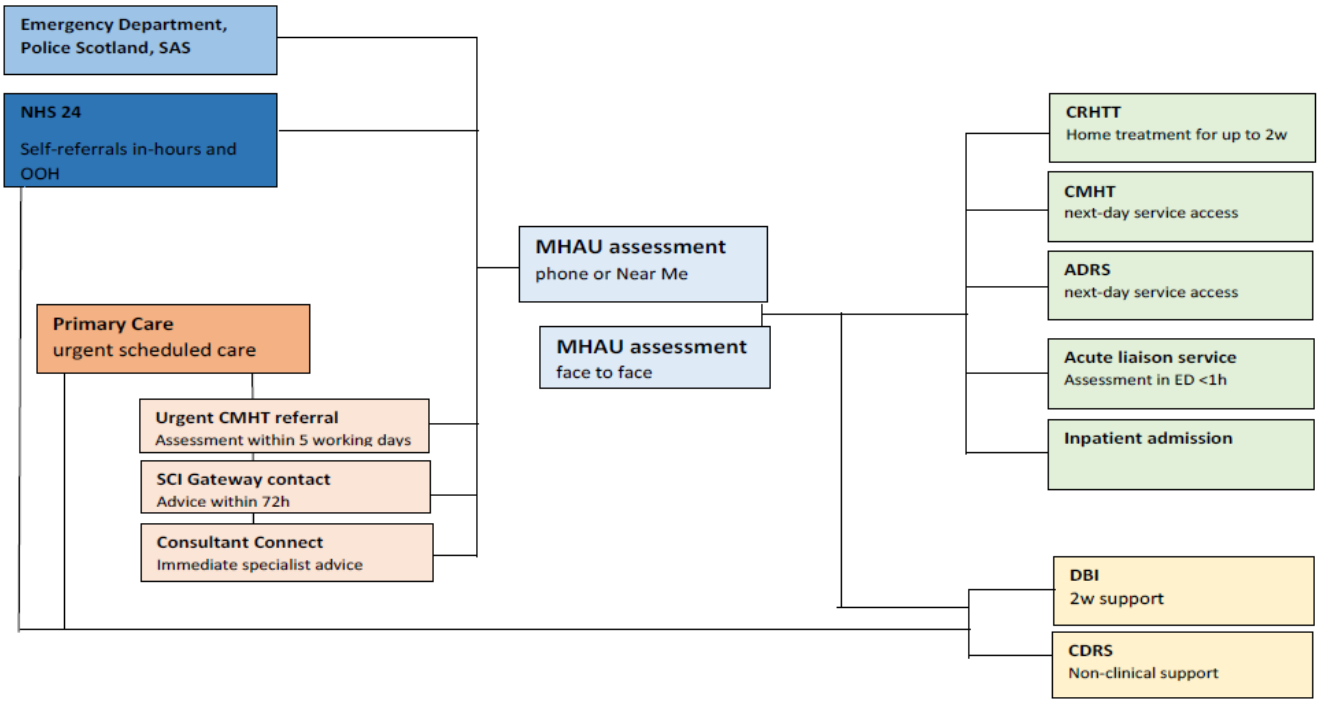
8. Mental Health

8.1. *Current position*

The pandemic has necessitated changes to mental health delivery across the Health Board area. Changes have been undertaken in both Health and Social Care Partnerships (HSCPs) as well as in our hospital settings.
Maintained Services: Core Mental Health (MH) services have continued to operate throughout the pandemic, ensuring continuous access to emergency and urgent care response. This has largely been made possible by the adaptability and flexibility of staff and adoption of a range of new ways of working including the wide scale roll out of IT and telephone consultation. Face to face emergency and inpatient care continues to be supported by new working practices, use of appropriate PPE and the adaption of patient pathways. At the time of writing, no inpatient units are subject to COVID-19 related restrictions on admission.

New Services and Service Delivery Models: Two Mental Health Assessment Units (MHAU) were new developments quickly established to divert patients away from hospital Emergency Departments. These continue to operate to Standard Operating Procedures in order to reduce footfall through EDs, and support Police Scotland and the Scottish Ambulance Service. Data has shown a reduction in ED attendances, significant uptake by Police Scotland, with positive informal feedback from all stakeholders and service users. Should success continue, the Board will consider roll out across NHSGGC.

Figure 1 – Modelling a post COVID-19 UCC Pathway for Adult, OPMH, LD and Addictions care groups



MHAU staffing resource is currently delivered by re-assigned staff, but this position is not sustainable as services remobilise and staff return to their substantive roles. A business case is being developed to establish a financially and clinically sustainable service model. Although still to be confirmed, that model will require significant integration and redesign of the various elements of unscheduled care, as outlined in Figure 1. A key aspect of the model will be to move from “unscheduled” to “scheduled” care as far as possible.

Creating, co-ordinating and establishing new systems for the public to access mental health and well-being information, resources and supports has been required during COVID-19. This includes the staff welfare response for a variety of workers not just NHS staff.

Paused Services:
At the onset of the pandemic all current mental health patients were prioritised using a “red, amber green” (RAG) rating, depending on their needs and level of care provision. Red and Amber patients continued to have planned contact. Work to re-establish care for ‘Green’ Category patients has been underway since mid-June.

Mental Health services across all HSCPs/NHS GG&C adapted their local service responses flexibly taking account of local infection rates, staff absences and need. The majority of ‘routine’ work carried out within the service was affected from March by the need to redeploy clinical staff. All teams maintained contact with patients in keeping with their needs. Referrals for most services reduced throughout April and May reduced for Attended appointments (which include NHS Near Me and telephone contacts) were typically 30%-40% lower than the previous year, though a small number of teams maintained activity at usual levels. Overall, CMHT caseloads reduced by 10%-20%.

Work to re-establish routine care for all patients has been underway in CMHTs and PCMHTs since mid-June 2020. Some aspects of work remain challenging due to infection control measures. For example, it is not possible to return to therapeutic group work in person while maintaining social distancing, but most electronic platforms are not able to meet clinical requirements for this kind of work.

Commissioned services have continued to receive NHS support and many have moved to on-line working. A new Digital MH work stream has been set up to facilitate innovation and to coordinate and extend existing eHealth provision.

Reduced Services:
Almost half of the Health Improvement and Public Health workforce across GGC have been re-aligned to pandemic response services, most which require to remain operational for the next phase of the recovery period. This significantly reduces the capacity to manage and deliver health improvement programmes, many with potential implications for public mental health.

8.2. *Planning for Recovery/Remobilisation*

The early phase of recovery planning included a significant focus on reviewing and learning from the business continuity models put in place, and to consider the impact of COVID-19 on future models of care including the impact of disrupted services, the need for ongoing social distancing measures, the impact on estates and facilities, and requirement

for adequate PPE. This has included a review and critical evaluation of alternative models and the technological response in the context of mental health.

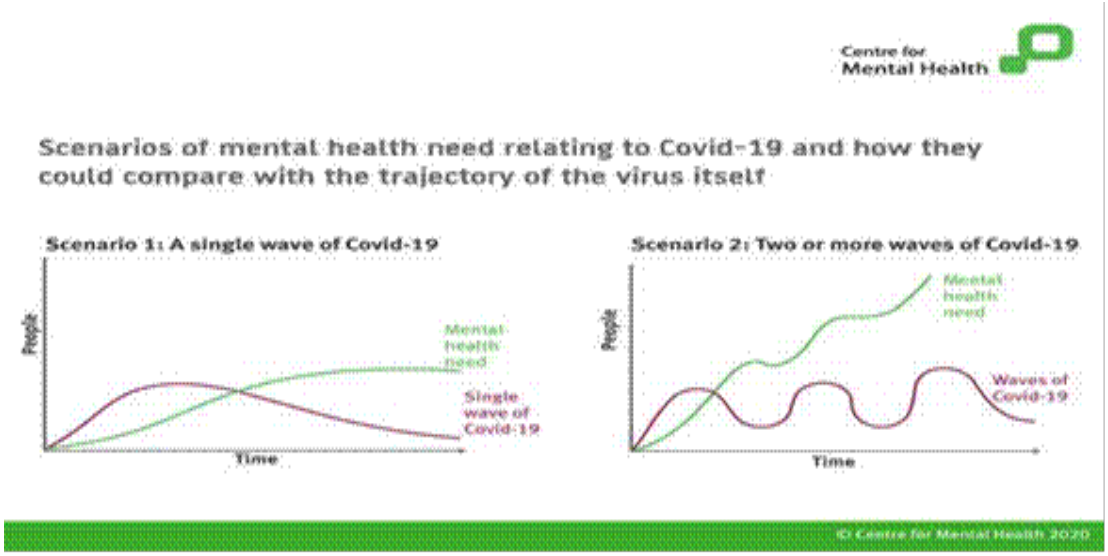
The broad socioeconomic consequences of the pandemic will have a significant impact on future demands on mental health services and would include social isolation, bereavement and the financial and economic impact of the pandemic. The Board recognises the particular needs and risks experienced by a number of vulnerable groups including people with a Learning Disability, neurodevelopmental disorder, dementia and, severe and enduring mental illness. Evidence is already emerging of a differential impact for people who live in areas of deprivation. For example 20% of the population living in the most deprived areas make up almost 60% of all attendances at the MHAU. The disproportionate impact of COVID-19 on BAME groups is recognised, including structural factors operating within the NHS. And a working group on BAME mental health will be set up to with stakeholders to advice on service development.

NHSGGC will focus on programmes within five key Public Mental Health categories;

- Building resilience and maintaining the mental wellbeing of the population
- Addressing loneliness and social isolation, recognising the needs of groups who are often more isolated by language, dementia, cultural and/or disability
- Responding to trauma, distress, suicidality, and the needs of people with pre-existing mental health and allied problems, as well as support needs around loss and bereavement
- Addressing underlying drivers of poor mental health – including current and anticipated rises in unemployment, material hardship, people at risk of violence, carer stress and endemic discrimination
- Support mental health and wellbeing of staff and volunteers, not just in the initial crisis phase but in subsequent phases, as evidence points to the potential for long-term trauma effects

8.3. *Future Demand*

It was noted in the last iteration of the plan that an increase in demand for mental health services is anticipated that is directly attributable to the pandemic.



This anticipation remains and there is a close correlation between demand for mental health support and austerity, economic recession and widespread social disruption. Service use data shows significant increases in caseloads over the five years to 2019, (with the largest increases amongst people aged 14-29y). That trend is expected to increase post COVID-19 and unscheduled care presentations to MH are already 50% higher than the equivalent period last year.

The combined pressures of COVID-19, unemployment, economic problems and Brexit-related disruption mean that demand is likely to continue to increase, particularly in areas of existing socio-economic deprivation. Data from the Mental Health Foundation shows that compared with people in work, people experiencing unemployment were twice as likely to say they are “not coping well” with the stress of the pandemic, and suicidal thoughts were twice as common in the unemployed group. The Centre for Mental Health estimates that at least half a million more people in UK may experience mental ill health as a result of COVID-19. On a pro-rata share by population, that would represent about 9,000 extra cases in NHS GGC; the real figure would be higher if deprivation were taken into account.

Estimates of future demand are necessarily difficult. However it would seem reasonable to plan increased demand for mental health services for the first year post COVID-19 as follows:

- Unscheduled care increased by 40-60%
- Referrals for scheduled clinical care increased by 20-30% (including much higher increases in people <30y)
- Increased stress, distress and common mental health problems in community settings increased by 30-60%.

The true figures may be significantly more or less, and activity data will be closely monitored to allow service services in GG&C to respond flexibly to changing patterns of demand.

8.4. *Public Mental Health Response*

The Public Mental Health response is vital given the continuing circumstances, predicted escalating demands and anticipated social and economic impact, and community feedback on mental health challenges. Work to enhance community resilience is underway and focused around a number of programmes of work. These include:

- Public Information - Ensuring a comprehensive suite of public information resources on key mental health areas are developed and shared with public and via partner agencies
- Community Kindness - Multiple neighbourhood and thematic groups and organisations responding to identified need during COVID-19. Some activities have been funded by Scot Gov COVID-19 resources for the third sector which end in waves over the next few weeks and months. Work is required to retain some of these endeavours, including new volunteers, in longer term change.
- Capacity Building for mental well-being – Training services were disrupted. Trialling a digital platform for the delivery for training is now underway including via our commissioned training deliver partner, SAMH. A number of organisations are currently piloting 'loss' and 'change' training in response to local need and extending appropriate training packages e.g. Seasons for Growth
- Children and Young Peoples Mental Health – Currently Liaising with LA's to commence community well-being hub planning through Children's Services Structures in order to implement the task force recommendations. This includes providing counselling services in advance of schools re-opening and recommencing planning for delivery of the community wellbeing framework.
- Mitigating poverty - Child Poverty Delivery Plan development was interrupted to support community and shielding (+) public responses. Concern over extended family hardship and child vulnerability while there is a dip in Health Visitor referrals for financial advice.
- Primary response for circumstantial distress - Community Link Worker/Well-being Workers have, barring technological challenges and accepted referrals but delivery affected and in some cases altered to support primary care COVID-19 response e.g. with shielding patients in the initial phase.
- Distress Brief Intervention - Scottish Government have commissioned SAMH to provide a service across GGC NHS area for 16+ patients, accessed through NHS24. This commenced on 1st June 2020.
- Compassionate Distress Response Service - GAMH commissioned to provide an urgent out of hour's service within Glasgow between 5pm-2am daily for first responders to refer into which commenced on the 25th May, 2020.
- Staff Welfare - Four stage approach to NHS staff well-being is being adopted in line with pandemic stages. Continuing with staff helpline. A trauma impact is anticipated over the next 3-18 months. A staff screening tool is being developed for community planning staff across GGC for intervention where required.
- Suicide prevention – Board is preparing a revised programme of suicide prevention drawing on previous work on Suicide Prevention Concordat, summary of emerging

evidence on current and anticipated needs, range of training options considered for wider use. Glasgow City are progressing work and response arrangements to suicide clusters, including media / public relations and associated policies. Pilot programmes for delivery of suicide prevention awareness via online means are also progressing.

Engagement and partnership working between public health and the HSCPs is fundamental in delivery of the public mental health agenda and a number of key questions have been considered in agreeing the priority actions to be progressed between now and March 2021. These are:

- Local partnership mechanisms in each HSCP that will be used to manage public mental health through the recovery phase
- How best to build the public conversation on mental well being
- Preparing for the predicted increase in distress, trauma and suicidality
- How the public mental health effort can challenge discrimination and informed by equalities.

Based on this engagement and programmes of work already underway, a number of key actions to be progressed through to the end of March have been agreed and are noted below:

Public Mental Health Recovery	Key Actions	Timescale
Building resilience and maintain mental wellbeing of population	• GGC NHS Heads Up website will have developed and clear well-being components and onward supports • Schedule of limited Mental Health and Wellbeing and Suicide Prevention Training for those working with the public across GGC. Through real time on-line delivery + group work (when possible) as well as further delivery of the Healthy Minds brief awareness modules through a variety of formats • Programme of real time on-line and in person group delivery with the public across partnerships on emotional well-being e.g. sleep, anxiety, loss etc. • Programme of public conversations across all CPP areas on collective action to support mental well-being	February, 2021 October 2020 July-March 2021 December 2020
Addressing **loneliness and social isolation**, recognising the needs of groups who are often more isolated by language, cultural and/or disability	• Champion for the development of CPP specific Connected Scotland Strategies within all 6 CPPs in GGCNHS. • Pilot community on-line ventures e.g. virtual community centre's for regular connectivity in every partnership	Ongoing Ongoing

	• Digital Inclusion work plan in all partnerships and structured learning from the opportunities and challenges of providing online and blended support in the mental health field • Seek to secure investment to enable a network of winter social connectivity to mitigate isolation during the recovery period	Ongoing August – November 2020
Responding to **trauma, distress, suicidality**, and the needs of people with pre-existing mental health and allied problems, as well as support needs around loss and bereavement	• Create clear and easy mechanisms for services and members of the public requiring support in emotional crisis through 1. DBI programme and local Compassionate Distress Response Services 2. Community Stress Services 3. Primary Care • Develop the concept of an integrated social (prevention and link worker) and distress (community and primary care mental health) intervention team for mental well-being at a primary care cluster level. • Extend Trauma awareness and support opportunities for HSCP staff • Suicide Prevention Concordat early actions; pilot cluster response plan clusters for potential CPP adoption, as well as develop actions to strengthen youth and young adult suicide prevention areas • Continue to progress delivery of comprehensive school and community counselling services for young people • Develop and adopt an early years mental well-being framework for partnership delivery	October 2020 (Scottish Government dependant) March 2021 December 2020 Ongoing March 2021 September 2020
Addressing **underlying drivers of poor mental** health – including current and anticipated rises in	• All LAs across GGC published Local Child Poverty Delivery Plans • NHS participation in economic and social recovery planning processes	January 2021

unemployment, material hardship, people at risk of violence, and endemic discrimination	within all Community Planning Partnerships • Assist in immediate poverty mitigation measures • Strengthen robust networks of employability and financial advice support for patients through HSCP services • Zero Tolerance refreshed action plans in all HSCPs	Ongoing throughout 2020/21 Ongoing December 2020 December 2020
Support **mental health and wellbeing of workers and volunteers**, not just in the initial crisis phase but in subsequent phases, as evidence points to the potential for long-term trauma effects	• Helpline call handlers training on emotional well-being and suicide prevention and clear onward referral routes • Work with the CVS network to support third sector staff and volunteers through training and support • Through liaison with Healthy Working Lives agenda, devise means of enhancing mental health support to priority areas of employers / workforces, linking with appropriate economy support structures.	September 2020 Ongoing Ongoing

8.5. *Clinical Priority Areas to March 2021*

Patients have all been contacted by telephone or letter to ensure they are aware of current arrangements within Mental Health and have been offered advice on how to contact services depending on their needs.

An urgent care response has been maintained throughout the pandemic. Vulnerable patient groups and mental health services for children and young people have been prioritised as part of remobilisation planning to address the waiting list backlog.

As work has progressed to consider the impact of COVID-19 and in planning remobilisation and the future delivery of services, a number of key priority areas are identified as follows:

- Digital MH
- Unscheduled Care
- Inpatient Care
- CMHT and Specialist Community Services
- Psychological Therapies including PCMHTs
- Primary Care and Prevention

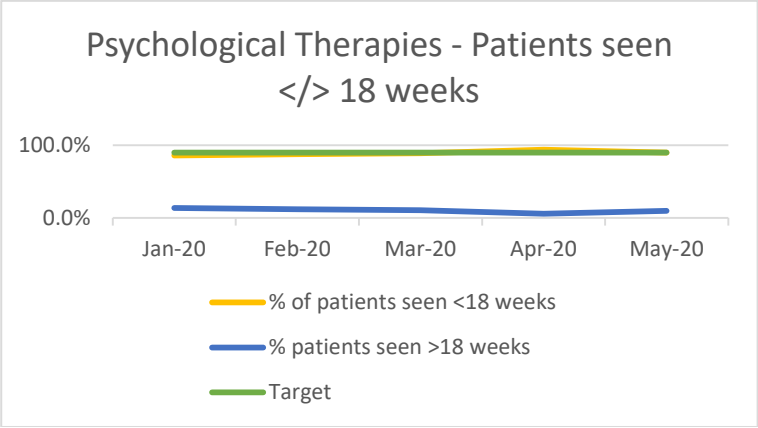
Child & Adolescent Mental Health Services (CAMHS)
At the start of the lockdown, continuity plans were quickly implemented to ensure clinical capacity was used efficiently, and patients were prioritised. This included rapid roll-out and provision of support for the use of NHS Near Me, which was extensively used during lockdown. This has led to a service that now delivers over 60% of all appointments remotely (via telephone or video).

Clinical capacity was also affected and reduced at the start of lockdown, initially to 75% but later to 90% of available staff at work, including some working from home, some clinic based work, and a significant increase in virtual consultations. A reduction in referrals has also meant that there are less children and young people than normal waiting under 18 weeks. This has caused an increase in the percentage of those who are waiting over 18 weeks. CAMHS has focused on reducing the size of the waiting list throughout the pandemic period, with a resulting decrease of over 900 children. We aim to continue this trend over the coming months with a range of improvement projects underway, continued use of NHS Near Me, options for supporting children and families who are digitally disadvantaged, and implementation of remote group consultations.

CAMHS are also working on plans for a waiting list backlog initiative. This is based on detailed modelling of demand (including anticipated uplift as a result of COVID-19), scoping capacity required in HSCPs, and supporting improvement activity. The success of this initiative will depend on a number of key requirements:

- Community mental health and wellbeing resources being available in HSCPs including the provision of School Counselling
- Confirmation of a digital solution to deliver remote group consultations (in the short and longer-term).
- Hardware being available for more staff to staff to deliver video consultations.
- Maintenance of planned staff numbers able to deliver treatment.
- Recruitment of additional staff for the waiting list initiative
- Reduction in current increased DNA rate

Adult Psychological Therapies Attendances
Adult psychological therapies have remained consistently high throughout the pandemic. The data below demonstrates that achieveing targets fluctuated and overall activity continues to recover during lockdown months.



Waiting List Management
Since the outbreak of COVID-19 services have not been able to see as many people to start a psychological therapy. The reconfiguration of resources to meet the specific demands of the outbreak resulted in the non-urgent delivery of PTs being less prioritised. Services could not see people as they would normally and waits have built up. Whilst the overall number waiting has not increased, the proportion waiting for longer has; and as services begin to address these longer waits and continue to do so over the coming months, the proportion of longer waits will likely be reflected in the overall monthly activity.

There are a range of mitigating strategies to address the long waits, these include levelling up capacity by recruiting to both current vacancies and newly identified gaps, as well as embracing e-health technologies to maximise virtual face-to-face engagement. Other strategies include increasing flexibility and sharing of resources across geographic boundaries and between care groups, increasing access by establishing a bespoke Board-wide team to co-facilitate group-based interventions with local services and recruiting a cohort of therapists deployed peripatetically to services identified with the longest and most waits.

Psychological therapies have an established activity management process. HSCP, Locality and Care Groups receive monthly performance data sets identifying performance to the area. The information is coordinated including numbers starting and numbers still waiting, and the local action being taken to address issues specific to the team and service. Performance for June sits at circa 80% of people starting a treatment within 18 weeks.

Board-wide waiting list inititives for psychological therapies are being established, mainly centering aroung PCMHT activity, through telephone and video conferencing only. Community Mental Health Teamsn will use assertive ACRT and PIR to increase capacity.

Actions and Plan
Actions specific to each area are detailed in the following table which identifies key priorities and associated actions being progressed between now and end July to support the initial phase of recovery.

Area of Focus	Specific Actions	Timeline
Consolidate a multi-faceted unscheduled care response based on MHAUs and including addiction services	• Two MHAUs remain operational • Business case for long-term MHAU effectiveness & sustainability • Co-location of OOH CPN with MHAU • Joint SOP with CRHTT, DBI, CDRS, NHS24 • Full capacity working to a sustainable model	Completed Mid-Aug 2020 October 2020 October 2020 Dec 2020
Digital Mental Health	• Increase remote consultations using phone and NHS Near Me, recognising the needs of	70% remote by summer 2021

	some care groups, e.g. in Older Peoples' MH. • Ensure appropriate IT in clinical areas and to support remote working for staff across all community MH services (including all psychiatrists and psychologists in training grades) • Procurement round forthcoming to ensure that all community MH clinical staff have access to equipment that would support remote working	New procurement round begins Aug 2020
Inpatient care	• Short stay bed occupancy gradually increasing from ~60% at onset of COVID-19 to ~85% now. Work in community services needs to limit further rises. Beds put "beyond use" in keeping with MH strategy if demand allows as community services return to normal activities.	
Community MH Teams for Adult and Older People's services	• Maximise remote working to ensure clinical areas have capacity to safely consult face to face where required. • Systematic implementation of Advanced Clinical Referral Triage (ACRT). • Implementation of Consultant Connect • Updated specification for joint working across substance misuse and MH services • Test of PIR pathway in two CMHT's	Ongoing to March 2021 Ongoing to March 2021 Oct 2020 Nov 2020 Begins Aug 2020
ADRS	• Support to all patients has been maintained throughout this period, but full range of interventions for "green" cases is restarting in a stepped way, including psychology and OT services. • Social distancing regulations have limited face to face consulting space, and this has been compensated for in part by maximising contacts with use of teleconference and increased home consultations. Restrictions on space are being addressed through building risk assessments to ensure appropriate social distancing and use of PPE.	Ongoing to Dec 2020 Ongoing programme now and beyond March 2021

	• Near Me capability is being developed but the risks of "digital exclusion" are high for this group, so mobile phones and SIMs have been provided to service users in greatest need. Future plans may include provision of mobile devices with data plans which would allow video conferencing and contact by email as well as voice and text. • In patient and residential services are expected to be at full capacity by Early Autumn.	
Psychological Therapies and Primary Care MH Teams	• Establish new GGC Waiting List initiative based on remote working for psychological therapies and relevant PCMHT caseloads. • Reduce waits <18 weeks by 50% Development of platforms and protocols to deliver group-based therapies online.	September 2020 Ongoing, to March 2021 Oct 2020
CAMHS	• Establish new GGC Waiting List backlog initiative based on remote working. • Improve compliance to waiting times standard • Achieve compliance to waiting time standard	September 2020 March 2021 September 2021

8.6. *New Ways of Working*

New ways of working have been identified across a range of service areas, as described above. Maximising digital technology is a major element of new ways of working, and will be overseen by a Digital MH Steering Group reporting to the MH Strategy Programme Board and the NHS GG&C eHealth Strategy Board.

The Digital MH Steering Group will oversee the implementation of existing programmes of work (including EMIS, MyPsych, NHS Near Me and HEPMA), develop service innovations (e.g. in new pathways for the provision of psychological therapy) and in public engagement (through NHS GG&C's *HeadsUp* mental health website and associated social media. Work is underway to enhance adaptive responses to stress and distress at a community and primary care level.

8.7. *Risks and Mitigations*

Responding to the risks and demands of post-COVID-19 prevention, care and treatment is a complex and multifactorial process. Neither future service demand nor opportunities and constraints relating to service delivery can be predicted with accuracy.

However, the plans described within have been drafted in full recognition of the interdependencies across the health and social care system, including issues relating to workforce, estates, transport, IT infrastructure, teaching and learning and data requirements. Those issues apply not only the Boards, HSCPs and their partners, but to a myriad of other stakeholders. These plans recognise the need to respond promptly and flexibly to new challenges, opportunities and information as they emerge in the coming months.

The highest risk is not COVID-19 itself, but the potential scale of new mental health demand stemming from longer term economic and employment consequences, as well as psychological impact of chronic isolation, anxiety and bereavement.

Consideration of the demand for functional service responses would be in keeping with mental health strategy “tiers” of service and stratified service responses. Scottish Government support and sharing of national needs modelling would be welcomed.

8.8. *Support Required*

For the period April- June, local mobilisation plans (LMP) include additional Mental Health costs for returning retirees to MH Inpatient services and for additional bank and temporary staff, including student nurses. A business plan will be finalised for Mental Health Assessment Units, including options to restructure service delivery to minimise the identified additional revenue funding.

- Whilst the scale of support required is broad-ranging, some key items of essential resource requested includes:
- Immediate costs of MHAU to be addressed (full year cost c£1.7m)
- Increase in unscheduled care of 50% addressed
- Support to upgrade IT, specifically for trainees (estimated cost £150k)
- Additional costs of waiting list initiatives for psychological therapies
- Mitigation of increased staffing costs due to shielding and increased illness

There are a number of areas where Scottish Government assistance would be appreciated to enable local progress on public mental health:

- Health Boards urgently require a clear plan for reinstating the nationally suspended Living Works and Mental Health First Aid training, as soon as pandemic requirements permit – (including early notice on resource ordering and record keeping systems).
- There is an urgent need for leadership and support from Public Health Scotland and the National Leadership Group for Suicide Prevention to help local areas in delivering suicide prevention and allied training, including guidance on how online and blended training might progress in a safe and effective manner. .
- There is a requirement for more rapid data systems to track changing patterns of suicide and risk - we would be keen to help pilot a system within the GGCNHS area

- Distress Brief Intervention service. Scottish Government have commissioned SAMH to deliver DBI across GGC NHS through NHS24 referral only. GGC NHS Board would like permission to negotiate supplementary referral and pathway management aspects in accordance with existing provision in each IJB.
- Public Mental Health Resource to respond to four key emergent areas;

    a. Enhanced suicide prevention co-ordination in all local authorities, with particular consideration for younger adults, extending training delivery, additional co-ordination requirements with local media and community bodies and to trial support for families affected by suicide over the next period. £195k in 2020/21, £390k 2021/22.
    b. Create a temporary Public Mental Health (PMH) recovery strategic lead worker in the six Community Planning Partnerships within GGC NHS to embed PMH within economic and social recovery planning. Through recruitment and secondment of public mental health improvement specialists into each CPP for this purpose. £176k in 2020/21, £530k in 2021/22

- Challenge social isolation over the winter period through a network of small winter fund grants (up to £2000) to local organisations supporting people isolated by hardship, vulnerability and/or disability, £320k for 2020/21 managed jointly between HSCPs and their respective CVS.

Key Points
• **Supporting the public mental health response to expected increases in demand for mental health support following COVID-19 and the economic disruption** • **Developing the digital mental health response, recognising the specific needs of some care groups** • **Consolidating the unscheduled care response to mental health and addictions needs, building on the Mental Health Assessment Unit model established during the pandemic** • **Addressing waiting list challenges for CAMHS and psychological therapies** • **Engaging with the Third Sector and other stakeholders as key partners in the remobilisation of mental health services**

9. Primary and Community Care

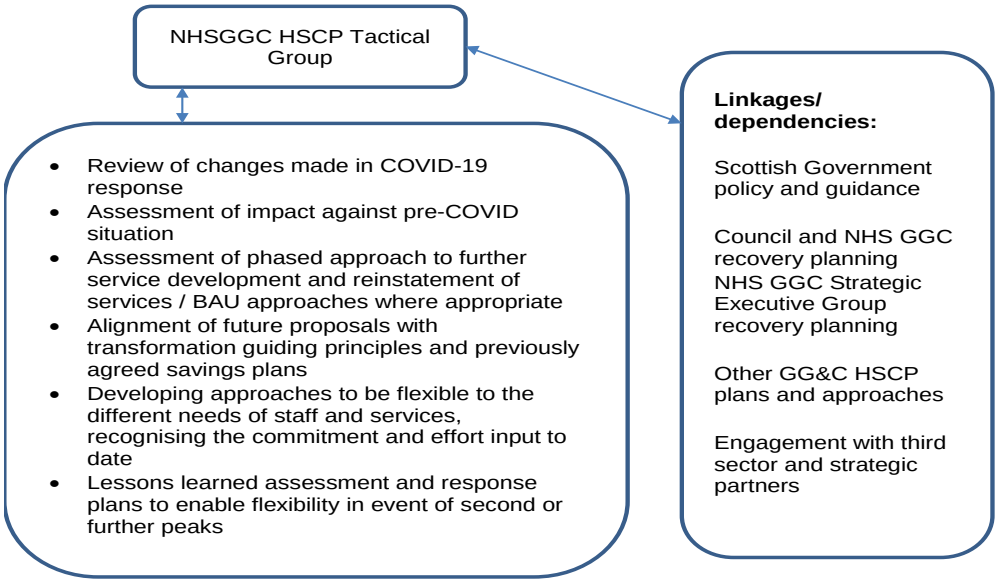
9.1. *Planning Approach*

NHSGGC's 6 Health and Social Care Partnerships have been collaborating and working together throughout the pandemic. This joint approach has been instrumental in delivering a GGC wide response which has involved a rapid and wholescale review of service provision; redesign of service delivery and access pathways; and significant changes to working practice that has supported continued delivery of many key primary care, community health and social care services. Service recovery and transition is both complex and multi-faceted and planning for remobilisation continues to be progressed in partnership across the 6 HSCPs. The Health Board have also continued to engage regularly with Argyll and Bute HSCP to ensure there are good communications, a consistent approach, shared information and the alignment of planning processes. HSCPs are developing recovery and transition plans that take account of the changing circumstances as restrictions on movement and access is gradually lifted, and are working together to support consistency of approach and best practice. Business continuity is likely to continue for many months, and during this period services will continue to evaluate and re-evaluate lessons learned and continue to evolve arrangements through the various phases of recovery.

There is a commitment across all HSCP Strategic Plans to tackling inequalities, achieved by working with localities to address the very different health and wellbeing issues noted across the different communities. It is recognised that exposure has been higher in deprived areas and outcomes have been poorer for those who have contracted the virus. Whilst lockdown necessitated the prioritisation of the workforce as part of the community and primary care, available technology and alternative methods of delivery has allowed, by and large, for resilience response services to be maintained. For example the profile of homelessness has changed over the course of the pandemic due to job losses within the hospitality sector. In addition, there is an expected increase in mental ill-health, from a lower level through to a more intensive need.

The majority of HSCPs have now re-convened their Strategic Planning Groups. These include partners from across health and social care, third sector, housing and, leisure. An early priority is to actively consider and agree priority areas to focus resource whilst recognising the disproportionate impact that COVID-19 has had on older people, those in poverty and deprived areas, and BAME communities. In this respect there is a commitment to working with communities and groups and directing resource to those who are most affected by the pandemic. This will include supporting critical health and social care, voluntary and community services to prioritise resource.

Planning Approach Overview



9.2. *Health and Social Care Partnerships Engagement*

There is engagement across all HSCPs with GP sub-committee structures. In addition to the Board's Primary Care Programme Board and various sub structures, each HSCP has a nominated GP Sub link GP to work on local issues and developments which would include representation on specific planning groups for individual strands of work. As part of COVID-19 recovery planning, LMC and GP subcommittee representatives have been and continue to be actively engaged in a range of service developments and pathways redesigns. Examples of this would include CACs, the development of primary care advice on COVID-19 pathways, Flu immunisation planning, and screening restart and throughout COVID-19, development of Testing pathways and processes involving primary care.

The third sector organisations, including voluntary organisation and contractors, are key stakeholders and provide invaluable input and resource that delivers support to local communities. Each Council area has a Third Sector Interface (TSI) providing a single point of access for support and advice for third sector organisations within local areas. Within each HSCP a third sector representative will be a non-voting member of the IJB and there will be a number of representatives on each of the Strategic Planning Groups. Additionally representatives would contribute to various other planning groups including those co-ordinating the COVID-19 response. For example, the majority of HSCPs had a third sector representative providing crucial contributions to the Local Response management Team (LRMT), some also including Scottish care, with responsibility for coordinating voluntary responses in the community to support the civil contingency efforts.

9.3. *Current Position*

Primary Care and community health and social care services have continued to operate urgent care services throughout the course of the pandemic, although activity dropped across most functional areas. In primary care, childhood immunisations also continued. A combination of people following public health messages about staying at home, to protecting services, family and carer interventions and staff being unable to respond to demand in the usual way, has resulted in this drop in demand levels. Activity is now picking up as lock down measures are reduced and paused services are phased back in. In addition to re-instating paused services and incrementally increasing capacity, additional challenges facing a number of community based services include, dealing with a backlog, but also in responding to increased new demands directly associated with COVID-19 including rehabilitation and increased mental health issues.

As with the rest of the Health Board, HSCPs have been working together to introduce new ways of delivering services through the use of technological advances. A Virtual Patient Management Oversight Group has been formed with two main business streams for HSCPs and for Acute services. For HSCPs, initial meetings have now taken place to discuss work required regarding performance and activity required, and representation will come from Primary care, mental health, AHP, Business Intelligence, Health Records and will co-opt as appropriate.

During the pandemic, HSCPs have continued to support COVID-19 services including PPE distribution, medicine collection, redeployment of staff to Contact Tracing and the general humanitarian resource.

Service		Activity Changes	Ref.
Day Care Services & Respite	Learning and Physical Disability Older People and Children	- Activity ceased during peak COVID-19 - Now: Approval for building based support services to resume	9.4
Social Care Services	Children & Family Fieldwork and Adult Protection	➢ Referrals reduced by up to 35%	9.5
	Care at Home – Commissioned and directly provided	- Pre COVID-19 c.84,000 care at home visits in a normal business week - Now, c. 75% of visits are being delivered on a weekly basis *Note: figures only relate to Glasgow South, Inverclyde, Renfrewshire, West Dunbartonshire and East Dunbartonshire however similar trends follow across the Board.*	9.5
	Addictions – Alcohol and Drugs	- Pre COVID-19 c14,791 appointments across GGC - During peak COVID-19: April – 16,023 appointments across GGC - May – 16,319 appointments across GGC - Recovery: June – 15,044 appointments across GGC	9.5
Community Nursing	Practice Nurses Treatment Room Nurses Advanced Nurse Practitioners (ANP)	- Practice Nurses, ANPs and Treatment room nurses have remained key to the COVID-19 response and will continue to support all forms of community nursing	9.6

<table>
<tr><td rowspan="3"></td><td>District Nursing</td><td>- Pre COVID-19 c8,959 cases on DN caseload
- c16,306 business as usual visits per week, 65,224 per week
- During peak COVID-19 March c68,000 DN visits, April c68,000 DN visits, May c71,000 DN visits
- Now, June c66,000 DN visits</td><td>9.6</td></tr>
<tr><td>Health Visiting</td><td>1st Visit:
- 96-98.5% of appointments carried out
6-8 week review:
<table><tr><td>Jan 2020</td><td>March 2020</td><td>w/b May 4th</td></tr><tr><td>84.7%</td><td>66.9</td><td>70.1%</td></tr></table>
13-15 month review:
- Fell significantly from 80.4% in January to 27.2% in May 2020
27-30 month review:
- Consistently >90% from Jan -</td><td>9.6</td></tr>
<tr><td></td><td>- March 2020
<table><tr><td>March</td><td>April</td><td>May</td><td>June</td></tr><tr><td>92%</td><td>85%</td><td>72%</td><td>57%</td></tr></table>
4-5 year review:
<table><tr><td>4.5 year review NHSGGC CHS Data</td><td>Count</td><td>%</td></tr><tr><td>Yes</td><td>3534</td><td>32.6%</td></tr><tr><td>No</td><td>7268</td><td>63.4%</td></tr></table></td><td></td></tr>
<tr><td rowspan="2">Community Health and Social Care (Allied Health Professionals)</td><td>Physiotherapy</td><td>- Pre COVID-19, 6,000 urgent appointments per month and c.21,000 routine appointments per month
- During peak COVID-19, c.800 urgent appointments per month and no routine appointments
Recovery plans:
- 30% of patients to be face to face
- 50% of urgent appointments at 3,000 per month to be carried out.
- 16,000 routine appointments to be carried out</td><td>9.7</td></tr>
<tr><td>Podiatry</td><td>Pre COVID-19:
- c.37,128 patients seen per month
- c.12,900 treatments per month
During Peak COVID-19:
- c.3,764 patients were seen per month (10% of caseload)
Recovery:
- Stage 1: 8,763 patients to be seen per month (23.4% case load
- Stage 2: 46.1% of caseload to be seen</td><td>9.7</td></tr>
</table>

		- Stage 3: 79.4 % of caseload to be seen - Stage 4: 100% of caseload to be seen and 100% capacity to be used	
	Community Rehabilitation	During peak COVID-19: - 52% reduction across a number of teams in GGC (Glasgow City, East Dunbartonshire and Inverclyde) from February to April 2020 Recovery: - Numbers are beginning to resume to expected levels for this time of year - Resumed to highest monthly levels of referral by June 2020	9.8
Primary Care Services	General Practice	- Chronic Disease Management is being closely monitored for possible long-term health effects of COVID-19 - Flu Vaccinations to increase from 2019 population - Screening to resume for non-routine calls in July/August 2020	9.9
	GPOOH	- Currently, 11,600 visits per month, with 1,600 home visits and 10,000 in person/remote consultations per month.	9.9
	Community Optometry	- Services to resume with 167 practices to open by late July 2020	9.9
	Primary Care Improvement Plan	- Planning Groups restarted and MDT staff returning to normal service - Actions aligned to priority recovery including CTAC and Phlebotomy delivery, vaccination transformation plan and pharmacotherapy services	9.10
Care Homes	NHSGGC Care Homes	- Circa 9,287 residents across NHSGGC 196 care homes - All care homes have been visited by a District Nurse during the pandemic	9.11

Note: While this table attempts to represent an overall picture of the community situation within NHSGGC, it must be noted that not all data included covers all of the Partnerships. HSCPs collect data in different ways and as such may not be represented in the same format. Now, Partnerships are working together in an attempt to record more streamlines data.

9.4. *Day Care and Respite Services*

In line with advice from the Care Inspectorate, all in-house centre based day services are currently paused, as are all similar services purchased from external providers. Social distancing constraints and the rise of infection rates in care homes has led to a reduced level of residential respite being provided, where possible, families and informal carers have often stepped in to provide additional support during this period.

However, for both Day Care and Respite Services, and associated models of care being paused, people have received alternative services on a 1:1 basis. Assessments have been undertaken for all affected individuals, with alternative support being provided as required.

These alternatives have usually taken place within individuals own homes to replace the congregate services and to meet specific eligible care needs.

As of mid-July, Scottish Government have given approval for building based support services to resume, in line with modified adaptions in PPE.

9.5. *Social Care Services*

Children & Family Fieldwork Activity, and Adult Protection
Whilst referrals and activity levels reduced across all HSCPs, by up to 35% in some areas, visits and direct face to face contact with the most vulnerable children and families has continued, with increased safeguarding contacts utilising technology based solutions. Participation in legal forums has continued, such as children's hearings which have been delivered virtually, with an increase over recent weeks to attendance in person.

For Adults, referrals, assessments and reviews of vulnerable adults has continued throughout the COVID-19 period.

Care at Home – Commissioned and Directly Provided
The provision of care and support to people living in their homes is complex and multi-dimensional, with complex workforce coordination, training and supervision requirements in response to vast numbers of service users and their families or carers over a full 24/7 operation. Provision in the six HSCP areas across GG&C is via a range of internally provided Locality Authority services and through third and independent sector contracted provision. In some HSCPs internal care at home services are very closely integrated with community nursing and rehabilitation services, in others it is standalone but with operational links. Internal and externally contacted care at home and housing support provision is regulated by the Care Inspectorate and provider organisations are answerable to the Care Inspectorate on matters of registration. All Local Authorities, through the HSCPs, will, however, have their own monitoring arrangements in place to ensure that what has been commissioned and contracted is being delivered, and that internal services are compliant and high quality.

Each HSCP retains its own strategic and operational planning and organisation of care at home and housing support, but collaboration and proportionate commonality is being facilitated across the GG&C area via the Board-wide ***Support for Care at Home Group*** made up of key leaders of care at home in all six HSCPs. This group has been meeting since April 2020 and produced the **Coronavirus (COVID-19): Greater Glasgow & Clyde Commitment to Care at Home** document in May 2020.

Since the outbreak of the COVID-19 pandemic each HSCP has been in contact with service users, carers and relatives to advise of the current issues and to seek assistance in providing care where possible. In addition, service user needs have been stratified to inform prioritisation of care, both in the initial phases where a worst case scenario was possible and going forward where we may move between spikes in COVID-19 outbreak. Work is underway through the recovery and transition process to ensure that any requirement to step up business continuity arrangements in the event of a spike in COVID-19 can be implemented quickly in response to the situation, albeit this is challenging in such a high volume and people-led service area. Rapid increases in capacity and/or changes to service to delivery models, particularly where service is contracted from a provider, can be costly and resource intensive.

Common guidance has been applied across all care at home and housing support providers in respect of the use of Personal Protective Equipment and universal precautions in relation to Infection Prevention and Control since March 2020. This has been governed by the guidance from Health Protection Scotland (HPS). Operating procedures are kept under review and can be changed as required in response to new scientific evidence to help prevent the spread of COVID-19.

Sickness absence amongst the care at home workforce across the GG&C area has not, so far, reached levels that were feared when the COVID-19 pandemic struck. Services have largely been able to cope with sickness remaining in normal or slightly above normal parameters, although this has been fluctuating. Where possible, however, HSCPs have pulled staff from day services and/or from wider service teams as volunteers and trained them to increase the resilience of the care at home workforce in the event of significantly increased demand and/or serious staff sickness absence. Whilst the work of care at home and housing support services are nowadays focussed on personal care it was anticipated that increased community support, through volunteers and community organisations such as community resilience/response teams, has been, and will continue to be, invaluable in supporting people to be safe and well in their own homes by taking on tasks such as food shopping/delivery, prescription collection, laundry etc.

Care at Home services continued to be provided to those who required service within the customer's home. Service was provided through a mix of internal service provision and externally purchased private provision, with RAG assessments currently in place for all service users.

Whilst demand initially reduced, due to family members and informal carers stepping up to provide support and care requirements, or through the need for self-isolation or hospital admission, the service continues to take on new clients as demand continues. The impact of reduction in service demand through COVID-19 has been partially offset by new demand for new service provision, and despite an initial reduction in demand, this is now increasing as families are restarting services which were initially suspended.

Care at Home services are now, at this point in July 2020, focussed on recovery and transition. All six partnerships in the GG&C area are looking to have commonality as to the application of any relevant eligibility criteria or access criteria for re-starts and new referrals for care at home. This approach will ensure that as many people as possible requiring care can access it, and that those who need extra support get it in response to fluctuating needs (e.g. post COVID-19, to prevent hospital admission, facilitate hospital discharges and to promote maximum independence).

Addictions – Alcohol and Drugs

During the months of COVID-19, walk in referrals stopped as public were not able to enter centres. GP and telephone self-referrals however continued.

Duty Rota ceased as staff were now on ADRS rota and working from home, with calls still being responded to.

Face to face appointments ceased however continued in cases of emergency. A number of HSCPs have concluded that face to face assessments are not essential as good quality information can still be obtained over telephone, however, in many circumstances face to face is preferable. For example in IPSU and vulnerable people.

Telephone consultations have been found to produce a quicker response.
All home visits were stopped. Currently, home visits using PPE are in place with plans to resume routine home visits to vulnerable service users and an assertive outreach approach to those who do not attend planned appointments.

9.6. *Community Nursing*

Practice Nurses
GPNs had reduced requirements to undertake normal practice activity for brief periods during the pandemic. This group will be key in essential long term condition management and as noted within the primary care section above there is a significant backload of patients who will require follow up through the recovery phase. Practice nurses will be deployed to support this work including supporting Anticipatory Care Planning and follow up which will be required. Much of this will be carried out using telephone and video consultations.

Treatment Room Nurses
HSCPs are at different stages of developing their Community Treatment and Care services (CTAC) as part of the Primary Care Improvement Plans. Development of this work was paused during the course of the pandemic. Treatment Room services are not yet established across all HSCPs and work is now being re-instated to continue to develop the model across all areas. Treatment room nurses have and will continue to be a key resource supporting the continuing COVID-19 response and opportunities are currently being discussed and developed with staff partners to ensure staff can be quickly mobilised where and when this is required. This would include to support CACs, supporting community nursing resource within district nursing and care homes and testing.

Advanced Nurse Practitioner (ANP)
ANPs have been and will remain key to the COVID-19 response and have been utilised in different ways. Some of the ANPs have been deployed to support Care Homes focusing on assessment, anticipatory care planning and avoidance of admission to hospital. This has been delivered in person and through use of technology based contact. In some areas ANPs have been working within GP practices which has benefited both practices and patients and is currently being evaluated.

District Nursing
District nursing services continued to operate throughout the course of the pandemic with over 6300 critical visits per week accounting for around 84% of the normal case load.

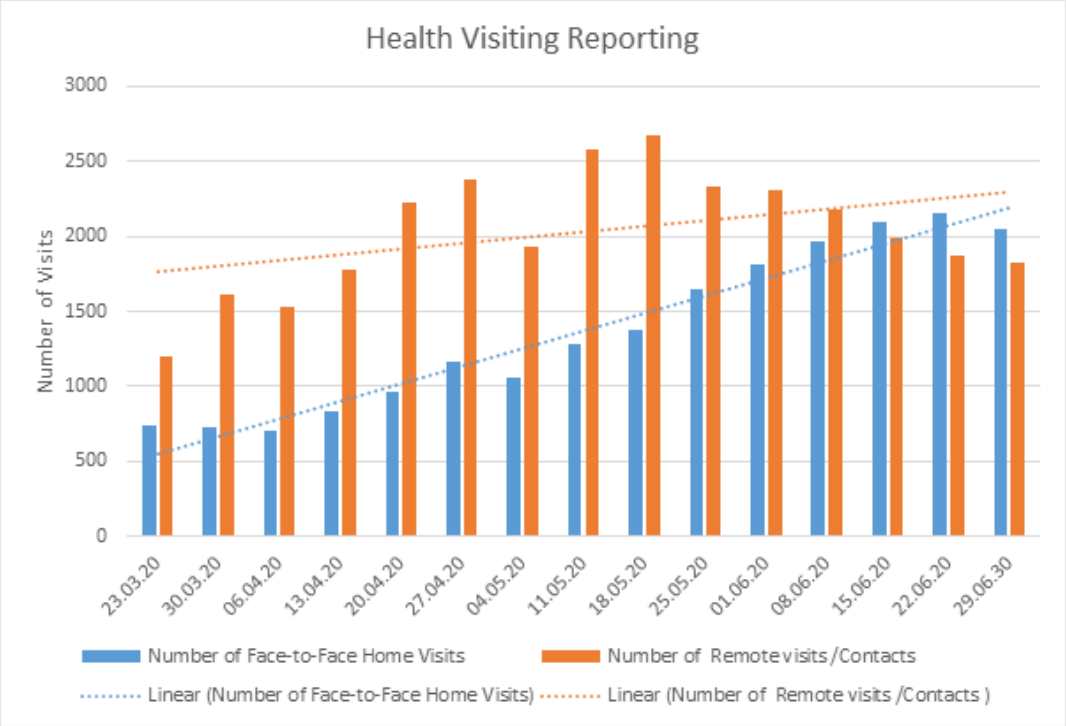
Within end of life care, all services have been maintained. There has been significant input from district nursing to care homes, with support provided to both patients and staff. In addition, district nurses across GGC have also been involved in the provision of end of life care for people in residential homes, providing the complex clinical interventions such as T34 syringe pumps.

Priority for access to services continues to be given to:

- Palliative and end of life care
- Patients who require administration of insulin
- Patients who require administration of essential medication
- Complex wounds requiring nursing intervention.
- Catheter management

- Patients who require administration of Enteral Feeds (including the administration of medication internally)/Total Parenteral Nutrition,
- Administration of hormonal cancer treatments

Health Visiting
Health visiting activity reduced significantly at the outset of the pandemic. However the activity levels have steadily increased over the weeks. Face to face visits are increasing in line with national clinical guidance and the balance has now moved from remote contact to home visits using appropriate PPE and guidance.



9.7. *Community Health and Social Care*

Specific planning is taking place across all community based health and social care services to support recovery and phase in paused services. As with primary care, this includes an ongoing review of ways of working and redesign to ensure that services are appropriate to patient need and can be accommodated given the need to maintain social distancing. Reverting wholescale to previous models of service delivery will not always be appropriate or possible and adoption and extending the use of a digital response will, in part, help to re-establish and scale up services to include routine care.
Detailed service plans are developing across all areas and a summarised version of these is detailed below.

Allied Health Professions
Phased planning for the phased re-mobilisation of services is taking place across all areas including physio, podiatry and speech and language therapy. Services are all at different stages of reviewing and planning to deal with backlog depending on the impacts. However the following give an example of the level of detail which is starting to emerge across the service areas and how service delivery is to be scaled up over an extended period of time through to Sept 2021. This will be subject to review and adaptation depending on further outbreaks of COVID-19 within the community.

PODIATRY SERVICES

PRE COVID

- All appointments held were F2F across 40 bases
- 37,128 patients were seen on a monthly basis
- 12,900 treatments were carried out per month
- 82% of appointments were held within a clinic setting
- 18% of appointments were domiciliary

DURING COVID

- Foot protection & some nail surgeries remained
- MSK, Ortho and all general services were suspended
- **3,764** patients were seen (10% of caseload)
- **4,019** activity per month (31% of capacity)
- **45%** of appointments were held within a clinic setting
- **47%** of appointments were domiciliary
- **8%** of appointments were held virtually
- 15/40 bases were used

RECOVERY PHASE 2

(July – September 2020)

- General podiatry patients invited back (0-4 weeks)
- All other services continue to be suspended
- **8,763** patients to be seen (23.4%)
- 47.7% of activity and capacity to be used
- Clinics are to see 43% of patients, with 47% being seen domiciliary and 10% virtually
- 15/40 bases to be used

RECOVERY PHASE 3

(Oct – Dec 2020)

- Most services to be reintroduced
- **17,116** patients to be seen (46.1%)
- Capacity of 70.8% to be used to deliver activity
- 15% of cases will be seen virtually
- Bases used will rise from 15 to 24

RECOVERY PHASE 4

(Jan – March 2021)

- More services reintroduced on a F2F basis
- 79.4% of patients to be seen
- Capacity and activity to be 86.7%
- 52% of patients to be seen in clinic setting, with 18% virtually
- Bases used to increase to 30

RECOVERY PHASE 5

(April – September 2021)

- Additional F2F appointments offered
- 100% of patients to be seen and 100% of capacity to be used
- 65% of patients to be seen in a clinic setting with virtual appointments increasing to 20%
- All 40 bases to be used

MSK SERVICES

Normal Delivery (Pre COVID)

- All appointments face to face
- **6,000** urgent appointments per month
- **21,000** routine appointments per month

During COVID (Peak Months)

- **2%** of appointments were face to face
- **600** urgent appointments per month
- All routine appointments **suspended**

Recovery (Phase 1)

- **< 5%** of appointments are face to face
- Routine services to be **managed remotely**
- New assessments **remain suspended**
- Gym and group work **remain suspended**

Recovery (Phase 2)

- **30%** of appointments are face to face
- 50% of urgent appointments at **3,000 per month**
- **16,000** routine appointments per month
- **33/35** bases being used to deliver services

Whilst all routine physiotherapy MSK out-patient appointments were cancelled, urgent referrals continued to be assessed and managed through telephone consultations, or through the use of NHS Near Me, with limited urgent cases being seen face to face. Now, physio service are starting to contact patients on the waiting list throughout July 2020, with the aim within the service o gradually increase face to face appointments to 30% and to continue to utilise digital technology where this is deliverable.

50% of business as usual urgent appointments are to be held each month and a total of 16,000 routine appointments to be seen per month which is around 75% of pre COVID-19 activity levels.

9.8. *Community Rehabilitation*

Within Community Rehabilitation, there have been three main categories of patient referred as a result of COVID-19 (in addition to those normally seen by Community Rehabilitation Teams): those discharged after hospital admission due to COVID-19; those who are deconditioned as a result of lockdown and/or shielding; and those with pre-existing long term health conditions which may now have been exacerbated.

Whilst community rehabilitation services stopped for routine face to face appointments, AHPs within the Community Rehabilitation teams have continued to use remote access as a first contact with patients. With staff predominantly remote working, initial patient review, in the most part, has been conducted via telephone consultation where patient triage is carried out, and in some cases 'Near Me' has been used to deliver virtual consultations where visuals are required to aid diagnosis or supported self-management.

In addition to a lack of IT availability for some patients, use of 'Near Me' has produced some specific challenges to the rehabilitation teams compounded by increased level of frailty and the deconditioning of patients post COVID-19 and as a result of being in lockdown and shielding. For many patients virtual consultation is therefore not possible. Where it is concluded that the use of virtual consultations adds an increased risk to patient, or, where rehabilitation is therapy dependant, AHPs will carry out face to face visits. Urgent visits have continued to be delivered face to face in an attempt to reduce emergency admissions or readmission, and/or where patients require supported discharge.

Community rehabilitation caseloads have changed as a result of COVID-19. In some areas, June saw unprecedented demand on rehabilitation teams. Data for the EMIS-using community rehabilitation teams across GG&C (Glasgow City, East Dunbartonshire and Inverclyde) shows a 52% reduction in referrals from February to April 2020 which has resumed to highest monthly levels of referral by June. Other Services have been limited and restricted, for a variety of reasons, which has caused additional pressures on community rehabilitation. Increased frailty in patients has been identified, with associated need for prolonged rehabilitation, and whilst future consequences of COVID-19 are not yet known, there is a presumption that the pandemic will continue to have impact on these services. Onward pathways from community rehabilitation services are still limited or non-existent as resources such as group exercise programmes have not resumed. This is impacting on the ability to discharge patients safely and timeously. Community Rehabilitation Services are also becoming aware of some patients who would previously have been referred for rehabilitation at point of discharge who have not.

There are unknown elements of COVID-19, with unexpected clinical outcomes. These are currently being closely monitored by clinical teams in both primary and secondary care, and will continue to be over the course of the coming weeks and months, to help identify trends in the system, as well as identify ongoing demand and capacity issues.

The long term impact of COVID-19 on patient's physical and mental health is not yet known given the novel strain of the virus. The prevalence of long-term sequelae related to COVID-19 is currently unknown, but these sequelae are likely to include post-ARDS lung fibrosis, chronic thromboembolic pulmonary hypertension and a range of potentially diverse multi-system and psychological problems. Without structured follow-up, identification and management of these problems will be extremely challenging.

Due to the infection control precautions in place patients' experiences in hospital have been unusual and isolated as visitors have not been allowed, staff have been using PPE which has limited physical contact and even verbal communication has been challenging.

High referral numbers are already noted by ID and Respiratory Thrombosis clinics (regarding post-COVID-19 fatigue and post -PTE follow up, respectively). It is proposed to establish a dedicated GGC wide service for COVID-19 follow up as a new service and to ensure that it offers a wider range of support than is usual along with coordinated access to a range of specialties. Access to a targeted physical rehabilitation programme will also be provided.

This has been designed by a multidisciplinary group, involving Respiratory Medicine, ICU, ID and Rheumatology, with representation and plans to deploy across all NHSGGC sectors (North, South and Clyde).

This will allow GP and patients to easily identify a source of support, ensure all patients get access to the necessary specialist support and also support ongoing learning and audit of the impact of this disease. Having a coordinated approach will reduce patient impact from having to travel to multiple appointments and use of virtual technology will minimise travel

People will be signposted to wider health and social care supports to address concerns such as money concerns and also supported to make healthy lifestyle choices addressing issues such as diet and smoking.

The creation of dedicated follow up arrangements will support the collection of data to ensure that we learn as much as possible about this disease, its impact on individuals and the long term implications. After six months any ongoing follow up will be incorporated into a clinic or clinics, subject to need in the acute division Follow up for patients who have been in ICU will be based on the award winning InS:PIRE model.

Survivors of Level 2/3 care will be invited to attend a F2F multidisciplinary clinic based on the InS:PIRE model. We propose that this will be hosted in the New Victoria Hospital. Patients discharged from Level 1 care will be invited for radiological follow-up and symptom review via a virtual clinic run by a COVID-19 clinical fellow at each site (QEUH, GRI, RAH), with remote Respiratory Consultant oversight.

Community Pulmonary Rehabilitation and InS:PIRE teams will work synergistically together. Patients will be referred between services as required. For those patients who cannot travel but require more in-depth rehabilitation than that which can be provided virtually, the teams will work together to ensure that individual patient needs are met. The funding requested ensures that there will be no overlap in services provided.

Patients meeting discharge criteria (return to pre-COVID-19 physical functioning and radiological resolution) will be reassured, and results communicated to primary care. Those with persistent symptoms, and/or radiological abnormalities will have appropriate investigations and treatment initiated and be referred for community Pulmonary Rehabilitation. Where investigation is required, pre-defined bundles will be used based on likely patterns of disease. Subsequent follow-up will either be by specialist clinic referral or a further COVID-19 virtual clinic review. F2F COVID-19 clinic attendance will be reserved for complex or uncertain cases.

This new service addresses the requirements of the recently circulated Framework for Recovery and Rehabilitation which requires:

- To ensure patients who have been admitted to Intensive Care and other secondary care areas have an assessment of their rehabilitation needs, are offered person-centred care, and are followed up appropriately after discharge:

- To explore models of care that support rehabilitation for those admitted to Intensive Care e.g. InS:PIRE programme and connecting with intensive care clinical networks and stakeholders across Scotland

- To engage with the Scottish Government Realistic Medicine team to build bespoke atlases of variation that describe the impact coronavirus (COVID-19) has had across the Scottish boards and partnerships, capturing prevalence, outcomes, inequalities and other epidemiological considerations that will inform how we should configure services going forward.

9.9. *Primary Care*

General Practice

An estimated 7 million consultations take place in General Practices in NHSGGC every year. Supporting sustainable recovery within General Practice is critical to whole system recovery and the effective management of patients in a community setting. It was previously noted that primary care has continued to operate throughout the course of the pandemic. In this respect all GP surgeries have adapted pathways and adopted new ways of working to allow them to continue to see and treat patients. As part of the remobilisation plan there is a focus on 3 particular areas where pressures will be significant in terms of mobilisation and catch up and within these there is specific planning taking place. These are noted as chronic disease management. Flu vaccinations and screening. Planning for these includes a review of ways of working, redesign and consideration of innovative solutions which will ensure that services are appropriate to patient need; reverting to previous models may not always be appropriate or possible and this is particularly notable in planning for delivery of flu vaccinations to the population.

- **Chronic Disease Management (CDM).** Effective chronic disease management for specific long term conditions and multi-morbidity is a core part of general practice activity, working in conjunction with specialist services and the wider multi-disciplinary team working in and with practices. The speed and manner in which routine reviews can be re-commenced will influenced by a range of factors including availability of supporting services, further advice on risk stratification and prioritisation, and opportunities for redesign supported by virtual consultations, home monitoring and support for self-management. The COVID-19 pandemic presents an opportunity to increase MDT contribution to CDM through the new ways of working introduced, and a system wide review of pathways should be progressed. Quality Improvement in CDM post COVID-19 will be a key focus for clusters.
  The scale of Chronic Disease management activity in primary care is indicated by the prevalence figures for selected conditions set out below (2019). Prevalence of chronic diseases, including multi morbidity, increases with age and deprivation. There is an indication at this stage that there will be an increase in those suffering from long term health conditions, which are directly attributable to COVID-19.

Chronic disease	Prevalence (%)	No. people
Asthma	6.11	79,691
AF	1.71	22,343
Cancer	2.4	31,384
CHD	3.81	49,742
CKD	2.75	35,828
COPD	2.64	34,495
Dementia	0.64	8,340
Depression	8.16	106,498
Diabetes	4.87	63,551
Heart Failure	0.9	11,802
Hypertension	12.44	162,325
Enduring mental health needs	1.03	13,460
Osteoporosis	0.13	1,749
Palliative care	0.23	3,030
Peripheral arterial disease	0.77	10,012
Rheumatoid arthritis	0.53	6,888
Stroke disease	2.18	28,396

Polypharmacy and Rationalisation of Medicines

There is clear evidence of benefit from review of medicines taken for chronic disease management and reduction of inappropriate polypharmacy. PMG Primary Care agreed that the prescribing initiative for 2020-21 as delivered by HSCP pharmacy teams in GP practices should focus on polypharmacy reviews. With the changes to practice working due to the pandemic there will need to be significant change to delivery compared to original plans, but this remains an important area for patient safety plus management of prescribing costs. Under the lens of a pandemic, a number of changes will be required:

- Focus on review of medication timing especially for patients receiving social care support for medication so potentially reducing the need for social care visits
- Focus on de-prescribing noting the reduced phlebotomy services
- Review of medication compliance systems with focus on move to original packs if possible
- Reviews undertaken by phone or Attend Anywhere rather than in person if possible

All practices have been given the option to opt in to this initiative and regular updates on delivery will be provided through PMG Primary Care.

Flu Vaccination

- **Flu Immunisation.** Flu Vaccination is currently carried out primarily by general practices for the adult, over 65 and at risk categories. Whole system planning for delivery has started to meet expected demand (including any changes to eligibility and uptake) in the context of constraints on face to face contact, social distancing and requirements for PPE. Volumes are significant with the largest eligible populations as shown below (subject to any nationally defined change for 2020). In the context of recovery, it is anticipated that the demand for flu vaccinations will increase this year. There is also consideration of how a roll out of a COVID-19 vaccine will impact and

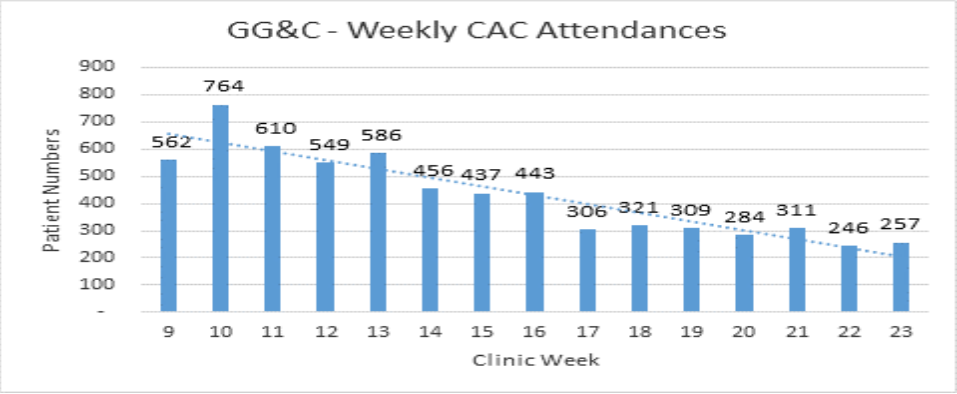
also be managed as part of the broader context. Current restrictions mean that capacity to deliver these in primary care will be reduced and therefore different solutions are being explored and with more specific details of planning noted elsewhere in this paper.

	Over 65		Under 64 "at risk"	
HSCP	**Population Over65**	**Cumulative Total Vaccinations (2019/20)**	**Population All-risk**	**Cumulative Total Vaccinations**
NHSGGC	201,879	149,618	182,122	77,473

- **Screening**. GP practices are responsible for delivery of cervical screening. Planning is in place for the restarting of national screening programmes through a phased approach focusing on the non-routine recalls in the first instance prior to recommencing routine invitations. Consideration is being given nationally to capacity in the system and the possible need to identify additional capacity outside general practice to allow the necessary catch up.

	Jul (non-routine)			Aug (non-routine)		
	Prompts	**Attendance (80%)**	**Referral to Colp**	**Prompts**	**Attendance (80%)**	**Referral to Colp**
NHSGGC	3750	3000	690	3707	2966	682

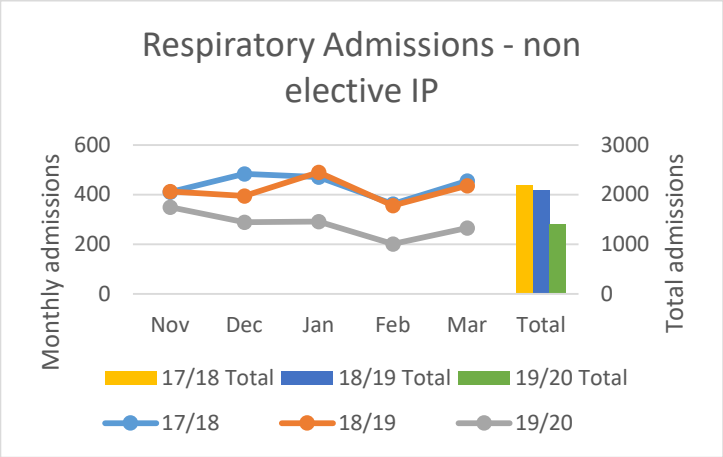
- **Continuation of the Community Pathway.** Ongoing planning for the continuation of the COVID-19 triage hub and CACs will enable suspected COVID-19 patients to be seen out with general practice and is key to supporting sustainability of GMS delivery. These will be kept under review in line with national guidance, patient numbers and any changes to case definition. In view of reducing demands the number of centres was reduced from 7 to 4 on 8th June, all geographically spread across the Board area. The table below shows the declining number of attendances through centres through to w/c 7th July set alongside the 'most likely' SG predictions for attendances.



Winter Planning

The current and future configuration of the centres is under review again in view of continued low attendance levels. This review includes plans for remobilisation in the event of a future COVID-19 outbreak, but also factoring in predicted increases which will be related to respiratory presentations over the winter period. In order to determine an

estimated respiratory referral figure, the non-elective respiratory admissions, as well as the ED respiratory related attendances, for the months of November – March have been reviewed over the course of the last 3 years.



GP Out Of Hours
GPOOH services have continued to operate throughout COVID-19, delivering consultations and home visits for urgent primary care issues. An appointments based system was introduced in June 2020 which supported GP consultations, followed by the introduction of Near Me from mid-June.

Community Optometry
During the peak of the pandemic the Acute Referral Centres took on the function of Eye Care Treatment Centres seeing urgent and emergency cases which required face to face visits. The majority of community optometry practices provided telephone and video triage and assessment with advice and treatment as required. Now, services are beginning to resume with 167 Community Optometry practices now open across NHSGGC, providing emergency and essential eyecare. Services are now preparing for the return of routine care as and when national guidance allows. Practices will continue to be supported with the roll out of NHS Near Me, access to clinical portal and ECS.

The remaining practices are primarily domiciliary providers who will recommence activity when visits are permitted.

Addressing waiting times within Ophthalmology is a key challenge of the remobilisation plans and there is an opportunity to promote more community based care while addressing the urgent requirement to address the COVID-19 backlog. Building on a strong history of collaborative working across Ophthalmology and Community Optometry, a dual approach will be taken forward including both engaging community optometrists to support provision within the Hospital Eye Services, and developing further community based provision with discharge of some patients to Community Optometry. Plans will specifically focus on Glaucoma, Medical Retina and Diabetic Retinopathy. Short term measures will aim to further develop experience, skills and training to support longer term expansion of community based provision enabled by EPR. A planning assumption of c 12,000 cases is being used to develop these plans further subject to confirmation of funding.

9.10. *Primary Care Improvement Plan – Recovery*

Delivering on the wider primary care priorities will depend on the availability of a range of other services and the next steps with the PCIP, including the return of MDT staff to practice activities and the next steps for further expansion of the team in line with contract commitments. Many of these priorities will place competing demands on both GP practices and HSCP staff and accommodation which have to be taken into account for PCIP delivery.

The PCIP updates for year three to March 2021 will have to take account of this context and set of drivers:

- Short term mobilisation plan priorities
- Capacity and delivery constraints (social distancing and PPE use)
- Longer term opportunities for redesign

Three of the priority areas in the PCIPs are associated with clear contractual commitments for transfer of responsibility; the next phase of development will be affected by this wider context as follows:

- Vaccination Transformation Plan. Implementation has been delayed until March 2022. Planning for adult flu immunisation will be a key priority across GP practices and HSCPs for winter 2021 and will impact on wider VPT planning.
- Pharmacotherapy - Pharmacy service to GP practices have continued throughout the pandemic, although the majority of staff worked remotely and the balance of work changed to deal with immediate priorities and take account of the reduced workload caused by fewer outpatient clinics and hospital discharges.
    - With more than 2 million prescription items generated in NHSGGC each month, effective management of repeat prescribing is a key area for workload and increased traffic through GP practices and community pharmacies. The potential for virus transmission through prescriptions or collection / delivery has resulted in many GP practices actively discouraging patents and pharmacy staff from attending surgery premises to collect prescriptions.
    - One key method to reduce the footfall to GP practices associated with repeat prescriptions is for implementation of serial prescriptions. This is also one of the key strands of the GMS Contract Pharmacotherapy Service specification. Working with local stakeholders a task and finish group has developed resources and agreed patient inclusion criteria to drive ambitious growth in serial prescribing with 9004 patients switched onto serial prescriptions in June 2020. Work has taken place with the LMC to develop a programme of work called Pandemic Annual Medication Service (PAMS), to support delivery of these objectives by practice administration staff. Rapid implementation is a vital step in planning for a potential second wave. Benefits include reduced footfall and workload for GP practices, better planned workload for community pharmacies, reduced waste and improved patient pathways.
    - Additional agreed pharmacotherapy priorities will focus on review of the workforce model including remote working and ‘hub’ models, support to care homes, polypharmacy and closer working with community pharmacy to support delivery of new services such as Pharmacy First.

- Community Treatment and Care services, including community phlebotomy. In order to support virtual consultations, access to community phlebotomy is seen as essential to enable tests and investigations to take place to inform assessment or as a follow up from a virtual consultation. This was already a core priority area for the PCIPs through the establishment of CTAC and community phlebotomy arrangements, but one where challenges to implementation and affordability had already been identified. Expanding access to community phlebotomy for acute requests would bring significant potential benefits. However, there is a risk of competing pressure for resources (staff and premises).

Learning from and responding to COVID-19 will also influence the delivery of the other areas of the contract, for example:

- Urgent Care. Review in the light of support to care homes and whole system unscheduled care planning, including opportunities of virtual triage and assessment.
- Mental Health. Existing PCIPs were aligning with Action 15 delivery. Mental health impacts of COVID-19 in the short and longer term are identified as a significant risk and planning for the mental health element of PCIPs will need to take account of the change in volume and nature of demand and be aligned with wider Mental Health services recovery planning.
- Across all priority areas, the potential for remote working and use of platforms such as NHS Near Me to support MDT discussion will influence deployment across practices.

9.11. *Care Homes*

There are 196 care homes across the Board area delivering care to circa 9,287 residents. From mid-April –July 14,025 daily calls have been made by HSCP commissioning to care homes. Training, webinar, guidance and support have been provided on a wide range of topics. Protocols to support care homes with staffing, psychological support have been put in place).

A governance and assurance framework was agreed by the 6 Chief Officers, Chief Executives of the Councils and the Chief Executive NHSGGC. This sets out daily calls, daily huddles and week multi-disciplinary meetings. Oversight is provided by NHSGGC Care Home Assurance Group.

All older people care homes have been visited. Adult care homes have either been visited or planned visits are arranged. Nursing and commissioning staff provide assurance and examine care standards with the home any actions identified are monitored through a plan which is progressed through daily huddles and monitored on weekly meeting. Escalation processes are in place issues are escalated to Nursing Director and Chief Officers. A Quality Care Sub Group examines quality progress of the red care homes action plans.

Testing
There are a number of different strands to testing in care homes, including routine weekly testing for staff, and mass testing for residents when a case is identified. Significant progress has been made in testing programmes which has involved new services being

established, new reporting systems and learning for care homes. NHSGGC has worked hard to meet its target of testing 75% of staff on a weekly basis.

Resource
Learning throughout the pandemic, each HSCP has put in place additional commissioning staff to support their role in the activity of governance and assurance. The costs for the additional staff are included in the mobilisation plans.

Nursing staff have been involved in 196 visits, with many more involved in supporting residential and care home COVID-19 testing. Additional nursing leadership and capacity is required to ensure that robust governance and assurance remains in place. Demands for infection control nursing expertise within care homes has increased and will therefore require additional capacity moving forward.

9.12. *Phased Transition – August to March 2021*

Through the initial recovery phase there was focus on reviewing changes implemented, refining these to meet the changing circumstances, and where appropriate consolidating at least some of these as part of the 'new' routine service delivery. Paused services are being phased back in, in many cases by adopting new technology based approaches, there is a focus in primary care on re-establishing routine care for those with chronic health issues and long term conditions and a phased approach is being pursued to extending the range of primary and community based services.

Detailed capacity planning is now well underway across services and within this there continues to be complex implications and considerations for primary, community and social care services related to demand for services which is gradually starting to increase. A key outcome from this is expected between what we can safely delivery versus patient / carer expectation. As a consequence of the pandemic there is an increasing backlog that needs capacity to be addressed and there is also additional demands for community rehabilitation for patients discharged from hospital who are recovering from COVID-19. The ability to recover at pace is conversely impacted by reduced capacity related to social distancing and the consequential impact on estate and the functionality of services, enhanced cleaning regimes and turnaround times, and also the availability of staff due to absence and ongoing shielding requirement.

All 6 HSCPs have established Social Distancing/ Accommodation forums to review and develop their new working arrangements given the impact of social distancing and increased infection control measures. Risk assessments are being undertaken in each site to determine capacity, infection control measures and modifications required to meet these new standards and guidance. This work includes reviewing each service's use of the building, providing proposals on what capacity is available and then developing revised operational plans to enable service delivery. Along with determining if protection screens are receptions are required, provision of PPE for staff and patients along with increased cleaning schedules. Due to the high demand on community premises, range of services which operate across multiple sites and the volume of patients who physically require to attend clinics and appointments this is a challenge. There are also emerging new demands due to the anticipated significant increase due to the winter flu immunisation programme along with the proposals from Acute to use community facilities.

With the risk of a second wave or local outbreaks, uncertainties remain around financials, provider sustainability and workforce issues. Each service is continuing to review operational arrangements to identify new ways of working including the use of Near Me technology to determine whether they can sustain reduced demands on sites and the level of face to face contact, but this will not be feasible for some services such as Phlebotomy, Podiatry and AHPs. Revised service pathways are being developed and once finalised these will guide individual site planning arrangements to ensure required cleaning regimes are established, appropriate PPE is available and staggered occupancy arrangements are in place to enable social distancing. As each site plan is approved these revised arrangements will be implemented on a staged basis and continually review to ensure compliance.

Self-Management and Self-Care

COVID-19 has created a twin challenge to HSCPs through increasing demand and reducing resources in adults and older people's social care across NHSGGC. Whilst HSCPs have been engaged in a number of transformational change programmes over recent years, in an attempt to drive more efficient use of available resources, COVID-19 and the present situation has created scope for HSCPs to shift the balance of care, whilst maximising service user and patient independence through self-management and self-care, and achieving budget balance.

For this change to succeed, a serious, sustained and co-ordinated response to early intervention and prevention approaches, including the systematic application of the principle of therapeutic and purposeful intervention at every stage of the care journey, across the six partnerships, with a view to optimising rehabilitation and minimising escalation to higher levels of formal care at every point.

There are opportunities to develop place and local-asset based approaches in line with the new neighbourhood teams for older people's services; the key elements of the Primary Care Improvement Plan and the review of learning disability services. The proposals would see an increasing role for families and carers and communities, with potential new models of care around family support, and further support from housing associations and third sector organisations. This however brings with it a number of risks, as statutory service users, families, carers and communities may not yet be ready or equipped to manage the scale of change required to properly support self-management and self-care.

Hospital at home

In line with the above different working practices that have emerged to address the pandemic circumstances, a number of proposals to implement Hospital at Home are currently under review, for implementation in autumn 2020.

These will focus on care homes, through collaborative working alongside 'Commitment to Care at Home' which has been developed as a comprehensive package of measures with PPE, Flu and COVID-19 testing, training and clinical management. There will be an extension to existing HSCP services and teams, through enhanced support, links to Mental Health Assessment Units and continued expansion of Advanced Nurse Practitioners. Finally, specialty focus around respiratory and heart disease will be developed, due to high incidences of admission.

9.13. *Public Protection*

All partnerships continue to work to deliver their core statutory public protection duties. Public protection is an umbrella term that generally encompasses the following areas of work:

- Child and Adult Protection services
- Multi-Agency Public Protection Arrangements (MAPPA), which focuses on assessing and managing the risks posed by sexual and violent offenders
- Multi-Agency Risk Assessment Conferences (MARAC), where agencies aim to manage the risk of future harm to people experiencing domestic abuse
- The work of local partnerships that are focussed on reduction of domestic abuse and violence against women
- The work of local Alcohol and Drug Partnerships

In order for public protection work to be effective a multi-agency and multi-disciplinary approach is necessary. Social work, health, education, police, the Scottish Children's Reporter Administration, fire service and third and independent sector staff are all key partners and their effective engagement in public protection decision making processes is central to making safe decisions.

As such, where partners are advising that their own operational approach has to change as a result of the impact of COVID-19, we are working to ensure they can still engage where they are needed.

An example of this is the implementation of teleconference options for child and adult protection case conferences in order to ensure Police Scotland are able to continue to input, where they are unable to attend in person. The delivery of the technical requirements for this are being supported by Local Authorities.

As each area applies its Business Continuity Plans these key public protection functions continue to be a priority for delivery.

At present each partnership area is managing this work within its own available resources. Immediately following 'lockdown' there was a general down turn in most types of public protection referrals however referral numbers are now returning to average levels for this time of year, using previous years as a comparator. An ongoing upturn in referrals is anticipated as the impact of the pandemic begins to come to light as people begin to resume higher levels of contact with services and other people in their communities. This includes increased levels of risk arising from the pressure of being confined in families, within homes, coupled with the psychological and financial stresses of the uncertain environment. There is a therefore potential for cost and resource implication both in terms of general workload demands on services and teams and the potential for additional alternative placements or living settings for children and/or adults in order to secure safety. This is beginning to manifest in practice in some areas.

Should resource challenges arising from COVID-19 lead to any risk of inability to meet statutory duties, partnerships will collaborate at a whole system level to ensure those most at risk are effectively protected. The position in relation to this will be kept under regular review through the Chief Social Work Officers of the partnerships.

At a national level a weekly data collection report process has been put in place to overview core protection functions through each Local Authority area's Public Protection Chief Officers' groups. This data collection aims to reflect different ways of working at this time i.e. acknowledging that not all contacts are taking place face to face, and to take account of issues wider than those that are traditionally seen as formal public protection, for example, the operation of, and throughput to, the Local Authority Humanitarian Assistance Centres and the actions being taken by to contact children and young people who are not currently attending school or the children and young people hubs. The data shows that for the week 2nd to 8th July 2020 protection services across the NHSGGC area received 595 new child wellbeing concern reports from Police Scotland alone, a level comparable with the previous year. In addition in that week 98% of children on the child protection register across the NHSGGC area were seen by a professional, a total of 656 direct contacts in the interests of promoting and ensuring their safety and wellbeing. In the same week adult services responded to 325 adult concerns received and Police Scotland recorded 243 incidents of domestic abuse.

Justice Services (social work)
Criminal Justice Social Work services, both those provided in the community, and those provided in Prisons, continue to be delivered in line with statutory requirements, recognising and taking account of recent revisions.

The means by which these services are delivered has been reviewed to enable remote, flexible and virtual working where this is assessed as appropriate. In person direct assessment and supervision continues to be in place for those assessed as posing, or at, greatest risk.

Scottish Prison Service have undertaken an early release of identified prisoners and Health, particularly drug and alcohol services, and social work services have been working in partnership with Housing services where there is an identified housing need, and third sector, to support the release and reintegration process for people being released at this challenging time.

A key consideration for justice social work services in the immediate terms is action required to resume the delivery of the unpaid work element of community based orders. Unpaid work was suspended at the outset of the pandemic and legislation and regulation brought in to enable a 12 month extension to all affected orders. Unpaid work services are now resuming, albeit in modified and safe ways, and justice services are considering how they will deliver the outstanding hours, in addition to all new orders, within the required timescales.

Children's Services
It is essential that services continue to be delivered to those children and families who are subject to statutory orders of care or Looked After.

Vulnerable families, already assessed to be at risk or in need, will have additional pressure to cope with at a time when the usual universal support is unavailable and schools are closed. Risk factors will undoubtedly accumulate and there will be a need for the state to intervene in order to keep children safe. This will require providing alternative safe care arrangements: kinship, internal placements and external placements.

Ensuring the Community Health Services for vulnerable children continue is essential. Health Visitors are required to ensure the health needs of pre 5 children and new born babies are met.

Homelessness

Glasgow City and Inverclyde have responsibility for homelessness and manage the statutory function on behalf of the respective councils. Both local authorities are stock transfer so housing is provided by housing providers (registered social landlords). There is a duty to provide early help, accommodation and support to those people who are potentially homeless. Both adopt a Housing First approach and are working with Registered Social Landlords (RSL) to increase temporary accommodation stock. Standard protocols are being developed in homeless accommodation to manage complex cases where self-isolation is required.

In advance of the crisis and within the planning phase Glasgow and Inverclyde increased emergency accommodation capacity within hotels, B and B and Registered Social Landlords and released additional Temporary Furnished Flats. This has worked well across the 2 partnerships, over a 7 day period they provided emergency accommodation to over 250 households. Both continue to offer homelessness services.

In responding to the risks in Glasgow the homelessness services where people were sleeping rough or using the winter shelter which was closed, GCHSCP worked with third sector to identify hotel provision, funded directly by SG, with support provided by the re--provisioning of outreach support. In addition, GCHSCP purchased additional hotel capacity and TFFs to ensure that anyone presenting as homeless can be accommodated immediately, and further hotel spaces were purchased to accommodate people with NRPF (NO Recourse to Public Funds) who were accommodated in an emergency shelter and those who present as symptomatic to ensure they could self-isolate.

An issue with Inverclyde has been the reduced availability of staffing both as a result of staff absence and an increase in activity to support the uptake of new tenancies. At the same time Inverclyde have encountered significant challenges in supporting service users in the Homelessness centre who are reporting symptoms, but because of their vulnerabilities they are not able to self-manage the advice to isolate or maintain social distancing. This has resulted in the need to commission security staff for the building overnight.

As we move forward both partnerships remain confident that they have sufficient emergency accommodation provision however much of this will depend on early prison release, COSLA proposal on NRPF, staffing in hotels and the unpredictable picture moving forward. There is a significant dependency on RSLs relating to recovery in homeless services, and when they are able to restart letting.

9.14. *Dental Services*

In line with Scottish Government Route Map, CDO issued a letter dated 9 July 2020 and subsequently on 10 July 2020 distributed PCA (D)2020 10 - Remobilisation of NHS Dental Services (Phase 3) to the Board which indicated that from 13 July 2020 all General Dental Practices could see NHS patients for routine non aerosol care. This is in addition to practices being able to see patients for urgent and emergency care only, during Phase 2.

As practices reopen and begin to provide care to their own patients, this means PDS and HDS no longer have the sole remit to deliver primary care emergency dental service for all NHSGGC patients, however there is still a requirement at this time to deliver any urgent care that involves AGPs. This allows capacity to consider how OHD services may resume.

OHD has reviewed Scottish Government's 4 phases of "Variation for restrictions of COVID-19". As part of the remobilisation planning. This includes ensuring the needs of the most vulnerable and priority groups are taken into account. As part of our remobilisation plans across OHD we plan to:

- Review the current clinical offer to consider what is still able to be delivered, and develop in partnership a revised referral and acceptance criteria
- Undertake an analysis of patients currently waiting for treatment in line with ACRT
- Contact those in the most vulnerable or priority groups to determine their current situation and consider how care might best be delivered including new or alternative modalities of treatment, particularly due to restriction of access to General Anaesthetics for Paediatrics, Special Care patients and other vulnerable groups and those most in need
- Increase use of Near Me/Near Me to improve patient access

These remobilisation plans are being developed across PDS and HDS and in collaboration with Local Dental Committee and Staff Partnership.

Within Oral Health Improvement, digital technology has already allowed for a restart to the delivery of service to vulnerable families and care homes, and distribution of tooth brushing packs to the Educational Hubs has continued throughout the pandemic. Initial planning for how NDIP may restart is also being considered.

9.15. *Community Pharmacy*

Throughout COVID-19, community pharmacy service have continued to operate, although for a short period under reduced opening hours to enable social distancing and provide capacity to manage workload. The early weeks of the pandemic saw significant demands for over-the-counter medicines and consultations for minor ailments and common clinical conditions, in parallel to a 30% rise in prescription activity. Many of these consultations had the potential to involve signs and symptoms related to the patient's respiratory tract (e.g. coughs, colds, sore throats etc.) and as such may enter into areas concerned with communicable public health risk during COVID-19.

The national Pharmacy First scheme was due to be launched in April 2020 but will now be implemented in July. This scheme will now be open to all people registered with a GP practice in Scotland and will allow direction of all minor ailments to the pharmacy with possible outcomes of assessment, advice, treatment or referral. It extends the minor ailments service to include uncomplicated Urinary Tract management and impetigo treatment. Pharmacy First is supported by a national list of approved medicines for supply.

Pharmacy First will be implemented across all 219 community pharmacies in NHSGGC by the end of July. Local work has commenced with key stakeholders to further develop the capacity in community pharmacy to manage a range of minor ailments and common

clinical conditions with the potential to redirect patients to access care from their local community pharmacy first. The roll out of Near Me will facilitate patient interaction and remote consultations.

Key Points
• **Supporting primary care and community services to take advantage of remote consultation** • **Refocusing Primary Care Improvement Plans to deliver contract commitments and support recovery in GP practices including Chronic Disease Management** • **Re-establishing buildings based day care and respite services** • **Recovering care at home services across GGC with consistent eligibility and access criteria** • **Scaling up activity in MSK physio therapy and podiatry** • **Responding to increasing demand for rehabilitation services, particularly for patients recovering from COVID-19** • **Standing up dental services in GGC** • **Implementing Pharmacy First in July 2020 across all 219 community Pharmacies in GGC**

10. Enablers

10.1. *Infection Prevention and Control*

During the peak of the pandemic separate governance processes were implemented to ensure oversight of Infection Prevention and Control in Greater Glasgow and Clyde. Members of the Infection Prevention & Control Team (IPCT) are present on the Acute Tactical Group (ATG) and the Scientific & Technical Advisory Cell (STAC). Any guidance/protocols produced are reviewed by ATC and any documents with IPC elements are submitted to STAC for final approval. In addition, IPC Clinical Governance reports are submitted monthly to the Strategic Executive Group. IPC elements are included on the acute and corporate risk register both of which have been updated during the acute phase of the pandemic. HAIRT reports have continued to be produced. Incident and outbreaks are updated daily and reported as per HPS protocol.

The Board Infection Control Committee has recently started meeting again with the first meeting being held on the 15th June 2020.

Patients with COVID-19 are reported directly from the lab systems to the IPCT via IC net. This system is updated several times per day. All positive patients are individually reviewed by a member of the IPCT and advice given regarding patient placement into appropriate pathways. IPCT in GGC have been screening all patients in wards where individual cases have been identified since April 2020. Where two cases are reported in an unexpected area these wards are closed and reported to HPS. Run charts have been developed for each of the main sites and this will be included in governance reports going forward as will the nationally produced HPS reports on nosocomial transmission. Local screening protocols have been developed for mental health areas, which were substantially impacted in the early stages of the pandemic in order to mitigate the risk in this vulnerable group of patients. The Board continued to implement Chapter 3 of the National IPC manual during the acute phase of the pandemic and HPS have been updated on any incidents and outbreaks not only in relation to COVID-19 but all issues and assistance sought where necessary.

Additional cleaning of areas of high volume of patients or areas that are frequently touched

- Increased cleaning frequencies have been instigated in high volume areas across NHS Greater Glasgow and Clyde. A review was carried out by the Board's Estates and Facilities Directorate following engagement with infection control colleagues to support increased regimes and this is being monitored in line with the mobilisation plan.
- Advice has been issued to care homes and contractor services and the care home support systems are ensuing that this is in place
- Facilities managers and the IPCT have met weekly throughout the pandemic in order to identify priorities for services and share information and updated guidance as it has been issued. This has ensured that cleaning services have responded promptly in a rapidly changing environment and have been updated continuously as guidance has changed.

Built environment (water)

- Areas that have experienced reduced activity have been subject to regular flushing of water outlets. This is in line with existing guidance on water risk assessments and flushing cycles. The Board Water Safety Group continue to monitor this process.

Physical distancing

- A social distancing guidance document which provides advice and guide for staff on the maintenance of social distancing measures has been issued. A standard risk assessment has been developed and is being applied across the organisation. Progress is reported to the Strategic Executive Group. This is based on the HSE and Scottish Government guidance.

- Standard signs have been prepared and will be available beginning 6 July 2020. The Core Brief distributed on the 3 July 2020 includes additional information for staff.

COVID-19 Pathways

- All sites, acute and mental health, have red/green pathways for emergency patients and patients on arranged pathways use alternative entrances.

- A patient placement standard operating procedure (SOP) was approved by the Scientific and Advisory Technical Cell. This includes guidance on pathways, shielded patients, risk assessment and principles of cohorting. This document has been shared with Health Protection Scotland who have requested permission to forward it to the four nations IPC group.

- In addition mental health services have agreed a local screening policy with the IPCT. Patients in this area have presented with atypical symptoms and isolation of patients with cognitive impairment has unique challenges therefore, early identification was deemed important to reduce the risk of transmission in these areas.

Staff Movement and Rostering

- Staff movement - the Board's current IPCT policies include this requirement and a detailed patient placement SOP has been developed for COVID-19. Any movement is risk assessed by a senior nurse ensuring patient safety is paramount.

- The Board's Uniform policy is currently available for all staff. There are no facilities to launder staff uniforms in Greater Glasgow and Clyde. If there is significant exposure, staff are advised to dispose of uniforms as clinical waste and a new uniform is issued. Core brief and posters also issued alongside COVID-19 site for staff as part of Frequently Asked Questions.

Staff Health

Staff health and wellbeing has been integral to the COVID-19 response and to recovery. Advice based on HPS guidance is available from Occupational Health and on the Board's website. A dedicated Dermatology clinic was established for staff whose skin was damaged having worn respirators for long periods. A Core Brief has been issued on 3rd July 2020 acknowledging concerns with the FRSM masks and our contact dermatitis

service is working with Occupational Health to identify solutions and precautions. Procurement are working with NSS to source alternative products.

Key Points
• **All sites have maintained red and green pathways for emergency patients** • **Physical distancing guidance has been produced to provide advice for staff** • **To support staff health and well-being, advice is available on the Boards website**

10.2. *Personal Protective Equipment (PPE)*

Safety of staff and patients is our top priority and ensuring a reliable supply of PPE to services has been an important strand of work since the start of the pandemic. Governance structures have been put in place with a PPE group meeting weekly, this would be reinstated to a daily call if needed. All parts of the organisation have established PPE stores to keep supplies secure and stock levels monitored. There is a designated lead for all services for PPE to ensure information is made available quickly from services to procurement and vice versa. There is a dedicated point of contact within procurement for all PPE queries and the ability to respond 7 days a week. There is close working across health and social care to ensure citizens and staff in all settings are protected.
All plans for remobilisation of services include a requirement to explicitly specify the amount and type of PPE required so that stock levels can be adjusted. Any challenges in availability are immediately highlighted through the appropriate mechanisms so action can be taken.

Changes in national guidance which change the advice on PPE are translated into local action rapidly with communication to staff and guidance on use, cleaning etc.
As service levels increase the use of PPE and the associated costs will increase.
The procurement team work closely with NSS colleagues to ensure stock levels are maintained.

There is an anticipated issue following the withdrawal from production of two types of respirators. There are a number of staff who have only been Face Fit Tested for these masks. National efforts are ongoing to obtain an alternative product or agree the use of a different type of respirator.

10.3. *Medicines availability*

Supplies of a number of critical medicines were on occasion challenged during the COVID-19 pandemic. There is recognition at UK and SG level that use of some of these critical medicines will also increase as services recover. NHSGGC Pharmacy Services continue to monitor closely the stock levels of medicines on the critical ‘watch list’. These medicines are commonly used in ICU areas but some are also used during surgery, endoscopy and colonoscopy. There are a number of interdependency and it is extremely challenging to project usage; reports have been produced to review previous usage of these medicines within these services. Additional supplies are being sought to meet demand across the UK. In addition a core group of Pharmacy Services staff meet regularly to review usage and agree communication to the wider multidisciplinary team. In

addition work is underway with Chiefs of Medicine to consider protocols that discourage the practice of drawing up these medicines in advance of procedures to ensure that waste is minimised.

Oxygen was a key treatment for patients with COVID-19 and work undertaken by Health Facilities Scotland ensured that the supply available to all sites was increased. The oxygen capability of wards was assessed and likely demand modelled based on the national modelling for likely COVID-19 admissions and likely ICU admissions. This indicated that the available oxygen would have been able to meet the demand at peak. NSS are completing a national review of the demand experienced. This will allow the Board to review its assumptions and plan for any further waves. Consideration of electronic systems to support medicines supply issues including a pilot of prescribing info which provides visibility of stockholdings across NHS Boards.

10.4. *NHS Louisa Jordan*

The NHS Louisa Jordan (NHS LJ) was constructed at the SEC campus in response to the developing COVID-19 pandemic to support NHS Scotland with additional capacity to manage any surge in requirements for in-patients or critical care.
NHS GG&C provided extensive support to the development of the NHS LJ. This included providing senior medical leadership input, installing and supporting the IT / eHealth infrastructure and hosting pharmacy services via an SLA. Extensive medical physics support was provided to commission imaging equipment. Infection control input included providing senior medical sessions and data manager support. There was sharing of clinical policies and procedures including consent and Duty of Candour policies. Palliative care pathways were shared and it was agreed that GG&C would run the mortuary on-site.
At present, the NHS LJ has not been required for its original purpose but GG&C continues to link with the NHS LJ as other uses of the facility are explored. Discussions are ongoing regarding any pharmacy requirements and the potential need for any additional pharmacy SLA to support other uses of NHS LJ. Options that are being considered for the GG&C remobilisation plan include:

Teaching & Training
NHS Louisa Jordan – National Skill and Education Hub: Recognition that, the need for a large space to allow appropriate social distancing measures, led us to enquire about the availability of NHSLJ as a potential educational facility. Following a Board paper to the Scottish Government, the National Skills and Education Hub was sanctioned at the end of June.

NHSGGC was the first to use this facility on the 29th of July with the FY1 induction. Following the introduction morning, the FY1s will undertake ILS training and simulation training within appropriately distanced pods. The physical space affords 10 simulation pods and 10 clinical skills pods – this will support the large numbers of FY1 requiring training prior to starting on the 5th of August. Over the next few months we hope to utilise the National Skill and Education Hub at NHSLJ for further teaching and training – including ALS and ILS, simulation for postgraduate and undergraduate and clinical skills training.

- Vaccination: NHS LJ may be a valuable resource in supporting both flu and COVID-19 vaccination programmes. GG&C is exploring options with NHS LJ, which include

using the extensive refrigeration facilities within the pharmacy to store vaccines and the potential to organise mass, socially distant, vaccination clinics

- Radiology: Continued consideration of potential capacity to support CT pods at NHS Louisa Jordan
- Out-Patients: Physical capacity within out-patient areas in GG&C will continue to be limited by social distancing requirements. A digital first approach is being taken with all referrals being vetted using an ACRT approach. The default for out-patient consultations is Virtual Patient Management unless there is a clinical indication with the aim to undertake the majority of outpatients virtually. Where this is not possible or clinically not appropriate, face to face consultation may be required. GG&C is aware that pilot out-patient clinics are currently taking place at NHS LJ and if successful, GG&C will consider the potential capacity of out-patient areas in NHS LJ if physical capacity within GG&C is not adequate to meet the requirements for face to face consultation.

10.5. *Medical Training*

COVID-19 has had a variable impact on training - some clinical areas were able to continue to support training while other areas paused formal training. All parties agree that while the COVID-19 response allowed for training opportunities and experience, formal recognition of this is variable in units and specialties. In May, all Boards received a letter from NES asking Boards to restart formal education and training activity. Different units took differing timescales to get back on track with training while delivering on re-instating service. The aim was to get all areas ready for the August rotation and to get all trainees through an Annual Review of Competency Progression (ARCP) process to allow progression in training. As we approach the August changeover period we appear to be back on track with innovation and NHS Louisa Jordan (NHSLJ) supporting us to continue to teach and train.

The utilisation of virtual platforms during COVID-19, allowed training to continue. This modality was especially important for the FiY1 trainees who joined us at the end of April. Virtual teaching supported cross sector learning, improved attendance, allowed registration and feedback and recording facilities allow a repository of learning material to be available when required by our students and trainees. This method of teaching will continue for FY1 and FY2 mandatory teaching episodes and will also inform how we teach across the Board in the future. Innovation in teaching has been a steep but positive learning curve.

Virtual platforms are facilitating the FY1 introduction to Foundation training. Four hundred and fifty FY1s joined the West of Scotland Foundation programme on the 29th of July – 240 of those within NHSGGC. We hosted a broadcast from NHSLJ, allowing us to live stream to all West of Scotland sites and for trainees to join via individual devices. This modality allows appropriate social distancing while ensuring a consistent message to the West of Scotland trainees.
During the COVID-19 response, the undergraduate students were removed from clinical placements, but virtual learning continued. Our students will be returning to clinical practice on the 24th of August and now have key worker status. NHSGGC and the university are keen to ensure that all clinical experience lost over the past few months is

caught up and that the service supports the students returning to clinical placements with appropriate measures in place.

The role of NHS Louisa Jordan as a National Skill and Education Hub is described in section 10.4 above. Over the next few months we hope to utilise the National Skill and Education Hub at NHSLJ for further teaching and training – including ALS and ILS, simulation for postgraduate and undergraduate and clinical skills training.

As we progress in the re-establishment of training and education, we will reintroduce the internal quality management processes and collaborate with NES around the more formal quality management processes that are currently suspended.

The re-establishment of training is a priority. This will be an iterative process during which we will support safe trainee progress and ensure individualised training and education needs are taken into account.

10.6. *Finance*

The financial impact of the plans described in this paper will require detailed review and conclusion of cost impact for submission on the 14th August in line with the Quarter One return.

Ongoing discussions will take place during the next few months to clarify the funding position. Key challenges financially relate to the significant costs of PPE and forecast unachieved savings.

Funding for COVID-19 is unclear at this stage and will be discussed and agreed with the Scottish Government following the first quarter's financial return.

Further work is underway to clarify the pandemic costs with an outline provided below:

Area		Description	Type of Spend
Public Health	Test and Protect	Establishment of Core team to provide tier 2 service	Paper already submitted to S.G. and costs will be on the LMP on 14TH August £798k plus set up costs of £14k
	Health Protection Teams	Strengthen core Health Protection teams	Additional Senior posts, estimated costs of c, £200k.
		Strengthen local community support and resilience	Additional resources required, estimated costs of c£150k
	Vaccination Programmes	Planning estimates demand may be double that of previous years for Influenza vaccination.	Additional staffing costs, hire of community venues, additional refrigeration and equipment will be required. Initial cost estimate of £3m. Refer to sections 2.5, 9.3, 9.9 & 9.10

	HIV Outbreak	BBV testing	Need to have 'Catch up initiatives' which will have a cost impact.
Care Homes	Care Home assurance and Support Team	Team is made up of Assistant Chief Nurse for Care Homes, Infection Prevention and Control Nurses, Practice Development nurses.	Temporary posts till end March in the first instance. Estimated additional costs £212k
		HSCP's additional commissioning staff to support governance and assurance.	Costs are included in the COVID-19 LMP.
Digital Solutions	Support Near Me / PIR / ACRT	Investment in Equipment across all board areas to facilitate the changes and progression.	Rollout of equipment to support the virtual management of patients. Costs incurred to date included in LMP. Additional spend will be required.
Workforce	Mental Health and Wellbeing	To support our staff's health and wellbeing.	Provision of short term psychological and occupational health support over the next 24 months, with expected additional cost of: 20/21£300k, 21/22 £443k and 22/23 £93k.
Planned Care.	Acute elective care	In 19/20 the additional access spend was £28.9m plus cancer of £2.6m. Included in the 19/20 additional spend was the recruitment of substantive posts of £2.5m.	It is anticipated that a significant additional investment will be required for 20/21.
	Cancer	A range of actions are being taken to treat patients and manage waiting list. Cancer monies have been released and plans are being considered against this allocation.	Plans include: Additional theatre capacity is required for Robotic Assisted Laparoscopic Prostatectomies This will be met through extended operating sessions Monday to Friday and regular weekend sessions which will have increased costs. Enhanced staffing Exploring use of insourcing Re-Profiling of sites including extended days and weekend working.
	Endoscopy	A range of proposals are being considered both nationally and locally.	National proposals include the use of Capsule Colonoscopy, Cytosponge and Transnasal Endoscopy.

			Additional local proposals include: Use of waiting list initiatives, QFIT testing, Use of external capacity Enhanced staffing Increased decontamination capacity levels. Review of equipment provision
	IPDC/OP	To address the backlog a range of actions are being taken.	Use of waiting list initiatives, Enhanced staffing through recruitment to support gaps including multi-surgeon operating, Investment in Advanced Scrub roles. Further development of nurse-led services. Use of insourcing / private sector/GJNH Weekend working on chosen sites. Expand ERAS nursing provision across sites Collaborative working across West of Scotland Boards. Maximising productivity. Review of Equipment and instrumentation provision. Additional resource for training. Increasing AHP and ANP staffing to support Orthopaedics.
	Radiology	Use of extended days and weekends.	Waiting List Initiative costs Consideration of potential additional capacity requirements to access CT capacity at NHS Louisa Jordan.
	Orthopaedics	Addressing Orthopaedic Challenge.	Review core medical staffing Increase AHP and ANP staffing Increased theatre Capacity Increase access to GJNH Enhanced support to increase daycase rates Consideration of site re-profiling
Surge Capacity	ICU beds	Should a second wave occur doubling or tripling ICU bed capacity.	Forecast costs should a second wave occur will encompass additional staffing costs through bank, agency, increased enhancements, overtime and excess.

Unscheduled Care	SATAs	The COVID-19 LMP reflects the net costs incurred as staff were redirected to support as well as the use of bank & overtime.	As staff move back to substantive roles, the full costs of resourcing will be incurred. Final costs to be confirmed
	Community Assessment Centres	Developed through the pandemic and will continue to support over the winter and deal with the flu pathway.	Ongoing costs to be clarified.
	Flow/ Navigation Centres	The introduction of Flow Hubs to provide access to a senior clinical decision maker.	Additional clinical resources will be required. The model is under review.
	Expansion of POCT	Increasing the areas where POCT is delivered will require additional analysers.	Estimated requirement of 17 additional analysers.
Winter	Winter plan	In 19/20 and in 18/19 the winter spend has been c£6m	Spend is expected in the following: Additional bed costs Additional staff required in A&E and Assessment Units, Boarding teams Extended pharmacy hours Additional AHP support. Additional support to maintain red and green pathways over winter. Additional diagnostic support Home care staff Community Discharge Teams in evenings/weekends.
Mental Health	MHAU	Staffing has been supplemented through redirection of existing staff plus bank, overtime etc. currently included in the COVID-19 LMP.	As staff move back to substantive roles, the MHAUs will require additional staffing. Business case being finalised, immediate costs identified of £1.7m full year and additional IT requirements £150k.
	CAMHS / Adult Psychological Therapies	Increase Demand and Waiting List Backlog	Enhanced staffing to increase capacity. Use of remote working waiting list initiatives.
	Public Mental Health	Enhanced suicide prevention PMH strategic lead workers	Training and support 20/21£195k 21/22 £390k Recruitment/Secondment 20/21 £176k and 21/22 £530k Small grants estimated £320k

		Social Isolation over winter with support of small grants to local organisations.	
Primary care	Community Rehabilitation	Establishment of a dedicated GGC wide COVID-19 follow up service.	New F2F multidisciplinary clinic and virtual clinics at each site supported with additional staffing. Resource required: clinical fellows, remote consultant oversight, nursing support, clinical phycology support and pharmacy support. Estimated cost of this initiative over six months is £208k
		Increased demand pressures and changes due to COVID-19	Review of AHP resources required to meet changing demand.
	Community Optometry	Engaging community Optometrists to support Hospital Eye Services and develop community based provision.	Provision of additional capacity to support the Ophthalmology waiting list backlog. Additional costs being worked through.
	Community Phlebotomy	Expanding access for acute services.	Review of resource requirements in line with increased demand.

It is recognised that further work on the financial impact is required and this will be completed by mid-August.

Key Points

- **Additional public health costs are highlighted For Test and Protect, flu vaccination programme and BBV testing**
- **Investment in planned care capacity will be required to treat backlog and address waiting lists**
- **Ongoing COVID-19 costs will be incurred while the red and green pathways remain**
- **Winter costs have been identified as similar to previous years**

11. Conclusion

To deal with the Global Pandemic of COVID-19, NHS GGC put in place new services and greatly increased capacity to treat and care for a very large number of patients with COVID-19 both in the community and the acute sector. The peak of infection has now receded and there is a need to remobilise our services. This involves ensuring that there is retained and flexible capacity both within the community health and social care sector as well as in hospitals to continue to treat patients with COVID-19 as well as ensure any increase in cases is managed. We need to do this while dealing with the increased emergency activity which winter brings. Strict infection control procedures within all sectors are required and services need to ensure social distancing measures are employed to protect both patients/service users and staff. This will have an impact on the productivity of services as well as their mode of delivery.

This plan recognises the impact that COVID-19 has had on patients, staff and the wider population. We have described how we will work with partners to address health inequalities impacted on by COVID-19. The plan has been developed in partnership across the health and care system in NHS GGC and has been tested with representatives of the public and Third Sector through our Stakeholder Reference Group. This cross system working has resulted in effective decision making, informed by the interdependencies and relationships between the different parts of our system. We will continue working with stakeholders as we move to implement the plan, understanding the importance of clear communication with individuals, communities and staff in health and social care.

The pace and scale of change have exceeded anything we have previously experienced. We want to build on the successful new models of care and apply new ways of working to our programme of change and improvement. Importantly, we will review and evaluate new service models and pathways as we progress to ensure that the patient experience is maximised. Patient and staff safety have been paramount during the COVID-19 period, and continue to be so during remobilisation. This plan describes how we will resume activity in a safe way, considering PPE and physical distancing. Staff wellbeing and mental health is a key priority in NHSGGC, and a detailed action plan has been developed to support this.

This plan sets out the way GGC intend to balance all of these factors in order to ensure patient/service users receive timely and safe care whilst maintaining capacity to deal with any surge in COVID-19 patients.

12. Appendix 1: NHSGGC Priorities for Winter 2020/21

Introduction

1. Planning for the Winter within the context of COVID-19 is underway, informed by extant and recent Scottish Government guidance, learning and adaptation from the service responses to the pandemic and emergent external guidance such as the recent report from the Academy of Medical Sciences "Preparing for a challenging winter 2020/21".

2. Each year, our Winter Plan includes an evolution in our approach or a development that wasn't present previously. The experience of COVID-19 is shaping our thinking with further emphasis to manage presentation to urgent and emergency care. We are considering opportunities to apply clinical decision making to pathways where previously there was none or to add specialist/MDT input at an earlier stage than previously possible. Widespread adoption of digital tools and virtual working are facilitating this and we are taking it forward through the enhanced cross-system governance processes that have also emerged as part of our response to COVID-19.

3. The priorities that are described below consider:

   - Optimisation of whole system working and the necessity of minimising infection
   - Minimising delays and hospital capacity
   - Supporting people at home
   - Public health surveillance
   - Supporting staff numbers through workforce management

Demand

4. Under normal circumstances, understanding trends in demand is complex with variation between years and fluctuation across weeks. This disruption caused by COVID-19 adds to this, normal levels of presentations to ED and Admissions dropped considerably and although since have steadily risen are not at seasonal 'norms'. Furthermore, establishment of SATA pathways necessary to contain infection risks have also added an additional entry point and a 'new' cause of presentation.

5. The difficulties of modelling of COVID-19 into the winter mean there is little that we can confidently base assumptions on. Our public health teams are working closely with Public Health Scotland to monitor current trends and developments in projections will be incorporated into our planning assumptions as they emerge.

6. Our remobilisation plans are informed by weekly presentations from October through to the end of February last winter and projecting scenarios ranging from a 3% to a 9% uplift with constant reference to current levels of demand.

7. For this winter, November to March, we will assume:

   - emergency attendances will remain less than last year due to the introduction of the SATAs and the new pathways described below

- emergency admissions will increase by 2% from last winter

Priorities for Prevention & Mitigation
Minimising community SARS-COVID-19 2 transmission and impact – Supporting the public

8. Communications and public messaging are a critical tool in the Board's engagement with the public. We have an established "Know who to turn to" messaging programme across our media platforms and would to expect to replicate and develop further air and online radio campaigns. Last year, a key message was "Meet the Experts" to encourage people to make use of the local 'experts' within minor injuries units, pharmacies and mental health for swift access. This was supported nationally.

9. An important feature of the pandemic period has been the response of the public to national and local campaigns. Demand for our emergency services dropped considerably as the public stayed away from our ED and Minor Injuries Units. Whilst this assisted our services by reducing pressure an important concern is ensuring that the public are able to access service and understand the alternatives when they really need it. An important feature will be supporting self-care, linking with the Pharmacy First implementation and sign-posting to appropriate online advice.

10. Widespread adoption of telephone or digital means of communicating with patients has been prevalent across primary and secondary care. As we embed this innovation we will work closely with NHS24 as pathways and opportunities to redesign service develop, an important area being exploring the diversion of ED unplanned attendances to appointment based models. Support from the Scottish Government in the exploration, development and communication of these potential changes will be important.

Optimising the organisation of the health and social care system (minimise the infections acquired in health and care settings).

11. Prior to COVID-19 a high level of 'unappointed' activity (GP Out of Hours, ED, and MIUs) was evident with a high number of face to face consultations taking place. Influencing this demand was a priority for NHSGGC with focus last year promotion of alternatives to ED:

    - A separate Minor Injuries Unit at the QEUH is in place
    - Signposting protocol: An agreed schedule of conditions whereby clinicians were empowered to redirect patients who presented at ED. At the outset of the pandemic
    - Public Messaging campaign on conditions where there are alternatives to ED
    - Continued focus on frequent attenders at ED and addressing underlying reasons for presentation

12. Each of these are expected to be a continuing feature of our Winter Plan for 2020. Our priority is to shift towards a model that sees the transition of unplanned care to one where services can deliver a planned urgent care response alongside an acute emergency access route. This, coupled with the ongoing need to manage the

impact of COVID-19, will influence the future delivery model of unscheduled care across our Health and Care System.

13. GP OOHs services have undergone considerable change over the last six months, initially in acknowledgement of considerable challenges to maintain existing service and then in response to the pandemic period.

    - Changes to means of access: Alongside NHS24, previously patients self-presented at the Out of Hours sites. This have now been stopped and an appointments system introduced.
    - Referrals now receive a GP telephone triage allowing a clinical conversation to take place between the patient and GP or ANP remotely, only providing face to face care and consultations where required.
    - Near Me has now been adopted fully across all the Out of Hours hubs.
    - The workforce has been strengthened with continued recruitment
    - Specific requirements for the Vale of Leven and Inverclyde are being reviewed in the context of the particular challenges of delivery in these localities.

14. Community Assessment Centres were introduced rapidly in response to the pandemic and drew on the emerging GP OOHs service model. Over winter months, CACs will continue be used to review a number of respiratory illnesses as uncertainty will continue as to whether or not this is a case of COVID-19. CACs will become the point of care (POC) for flu testing.

15. Mental Health Assessment Units: These units were established to alleviate the pressures on hospital emergency departments. Patients are referred through GP/NHS24 and may then be referred to ED if required. Currently, MHAUs have been continued for a period of 3 months from June 2020 to enable further assessment of impact. The location of the units mean that they do not extend across the full geography of NHSGGC and this will be a consideration going forwards. It is proposed that mental health services develop the service proposition to enable GPs and GP OOH services to refer directly to the MHAUs. This would include the introduction of clinical conversations and Near Me remote consultations to deliver both a planned and urgent care response.

16. There are 235 GP Practices across the Board area which manage significant volumes of Urgent Care in hours. Our aim is to develop additional support to enable them to manage this with a range of options. It is essential that the ‘professional to professional’ conversations between community care, primary care and acute services are facilitated to allow relationship building, shared decision making and robust governance to support the management of risk. The opportunity is to utilise the learning from the rapid changes made during the pandemic period and embed into new ways of working such as the Community Respiratory Teams.

17. Patients with respiratory illness are at high risk of emergency admission and infection from flu and COVID-19. The continuation of the Respiratory Response services will provide specialist input to the care of patients with COPD who are high risk of requiring emergency admission during the winter. This service was created to provide a safe alternative to hospital admission for the chronic lung disease

population with the awareness of nosocomial inpatient spread and potential poor outcomes for those with severe lung disease. It provides a single point of access for patients and GPs and offers specialist support to care homes. The service is multidisciplinary with daily Consultant support and works across primary, community and secondary care. It is a cohesive team in Glasgow City, reflecting the scale of service and in other HSCPs, the outcomes are delivered within a suite of competencies of their community teams. The provision of oxygen to care home also assists with keeping people in their own homes particularly at the end of life.

18. We are exploring the potential to redesign the entry point to our Hospital Assessment Unit, introducing telephone triage, utilisation of consultant connect and alternative clinical pathways to divert patients to appropriate alternatives either within community responses or scheduled 'hot clinics' in hospital. This work is at a feasibility stage at present but with aspiration of trialling for the winter.

19. The national Pharmacy First scheme was due to be launched in April 2020 but will now be implemented across the 219 community pharmacies in NHSGGC by end of July. This scheme will now be open to all people registered with a GP practice in Scotland and will allow direction of all minor ailments to the pharmacy with possible outcomes of assessment, advice, treatment or referral. It extends the minor ailments service to include uncomplicated Urinary Tract management and impetigo treatment and is supported by a national list of approved medicines for supply.

20. COPD Rescue medication from Community Pharmacies will be fully implemented by the autumn.

Hospital capacity requires to be increased and available without delays in the event of a future COVID-19 surge while adhering to social distancing

21. Additional Bed capacity is critical to maintaining flow during the periods of high demand. In recent years, we have planned in the region of 160 additional beds across the acute hospital sites. Our current projections indicate that we should plan for 174 beds for COVID capacity, in addition to 80-100 beds for winter pressures.

22. Managing unscheduled care demand will continue to be challenging even with this additional capacity hence there will be a considerable focus on mitigation strategies to manage demand differently, optimise the use of acute beds and avoid delayed discharges. These include:

    - Flow Management: Last year, "Flow Hubs" were introduced on the three main sites to support co-ordinated patient movement through hospital from ED to discharge.

    - Where patients are admitted out with a 'specialty' bed base, Boarding teams have proven effective mechanisms to ensure there are no unintended delays within their patient management.

    - Expected Date of Discharge is now a core part of admissions procedure, recorded on Trakcare and supporting co-ordination of clinical management and discharge.

    - Further discussion is underway with HSCPs to consider alignment of a Discharge to assess policy, with the aim of addressing variation between the different Local Authority Social Care teams. This would start from the

assumption that for patients with a hospital of stay within 7 days, a detailed needs assessment is not mandatory whilst the patient is within hospital. Alignment of referral mechanisms to Social Care would also contribute to reducing delays.

- Use of community pharmacy for supply of discharge medication utilising clinical portal to communicate scripts and avoid delays between Immediate Discharge Letter completion and medication supply. A pilot has been concluded successfully and feasibility assessment for wider implementation is being undertaken.
- Supporting all of the above are a suite of dashboards which provide real time data on patient admissions and are available across acute and community teams.

23. Should there be a 2nd COVID-19 wave of a similar magnitude to this spring, the response would be a curtailment of routine elective activity releasing a further 400 beds. A reasonable planning assumption would be a repeat of the drop in the unscheduled care admissions that was observed but possibly not to the same extent.

24. We will continue to seek to maximise the overall elective programme during the winter period. During the festive period and the initial two weeks of January we will focus on prioritising cancer and urgent patients as well as utilising fully Day Case and 23 hour stay capacity. This will include maximum use of theatres and bed capacity on sites which are not the main acute receiving sites.

25. Board procedures for the management of Norovirus and infection control are firmly embedded and supported by IPCT training. There is close working with local Infection Prevention and Control staff and all receiving units to ensure policy and procedures are up to date.

26. Capacity requirements for Mortuary space has been reviewed and confirmed expansion from a base of 511 to 2000 spaces have been identified in hospital mortuaries and additional body storage facility. Further capacity may be accessed from the Louisa Jordan mortuary (230 spaces) as well as an additional body storage facility run by the Local Authorities which can be brought on line within 72 hours.

Supporting people at home

27. HSCPs have focused attention and invested in in-reach services to commence discharge planning early with acute colleagues. Teams are co-located on acute sites. The utilisation of real-time dashboards is allowing community teams to identify patients early during their admission hence bringing forward discharge arrangements. Approaches such as the “Focused Intervention Team” (West Dunbartonshire), “Hospital to Home” (East Renfrewshire), “Home 1st” (Inverclyde) and “Home for me” (East Dunbartonshire) are examples of dedicated multidisciplinary teams including AHPs, Elderly Care Advanced Nurses or Specialist Nurses focused on closer working with hospital teams to address unnecessary delays

28. In preparation for last winter, joint work across all six HSCPs developed a standardised approach to summarising Anticipatory Care Plans (ACPs) and integrating these with GP Key Information Summaries. This incorporated the adoption of the Rockwood Clinical Frailty score embedding a common measurement tool across primary and community services, building on the experience of West Dunbartonshire who were an early adopter. A digital platform has been established to allow this summary ACP to be incorporated within the patient's electronic record and accessible across primary, community and secondary care. This is complemented by a digital care management escalation plan that is completed within the hospital setting at the point of discharge.

    - People affected by COVID-19, either directly and recovering with resultant co-morbidities or those who have been shielding, will be risk assessed and any additional need reflected within an ACP.

    - The utility of the digital ACP summary is being considered across care pathways to better co-ordinate care and avoid hospital admissions, linking its use with other digital communication methods such as MS TEAMs, Near Me and Consultant Connect. The combined impact is strengthening multidisciplinary working across primary, community and secondary care clinicians as well as the Scottish Ambulance Service and Community Pharmacy.

29. Building on the above and from the different working practices that emerged to address the pandemic circumstances, 3 proposals to implement a "Hospital at Home" models of care are being considered for implementation this autumn; subject to available funding.

    - Care Homes: working with a cohort of Care Homes in North East Glasgow

    - Extension of existing HSCP services/teams: Working around central MDT hub to provide enhanced support at home, links to Mental Health Assessment, intermediate care beds and continued expansion of Advanced Nurse Practitioners into Community teams.

    - Specialty focus: Respiratory and Heart Disease which have high incidences of admission but where there is considerable experience that would facilitate alternative management at home.

30. Collaborative working with Care Homes in recent years has resulted in a number of quality improvements that have contributed to better management of patient care at the interface with hospital. The vulnerability of residents during the pandemic period has added further urgency to ensure effective support during winter. 'Commitment to Care at Home' has been developed as a comprehensive package of measures with PPE, Flu and COVID-19 testing, training and clinical management.

31. All of the above measures interface in some way with Frailty. As a priority of NHSGGC's strategic change programme (Moving Forward Together), work has been progressing over the last year on development of a standard approach to supporting Frailty. Although disrupted during the pandemic period, the identified action plan will recommence with a view to delivery in time for winter.

Public health surveillance, outbreak investigation and management for early identification and suppression of COVID-19 and influenza must be optimised to deal with any new waves of infection.

32. The NHSGGC Test & Protect service was put in place rapidly during the spring. It is currently in transition with the National Tier 1 service, consolidating interface operating procedures. A local stress testing exercise has been undertaken supported by Civil Contingencies and Army Liaison. By the time the winter plan is being implemented, the consolidated NHSGGC Test & Protect Tier 2 service will be fully in place. A workforce plan has been approved to recruit to an established service which will be supported by bank and a 'reservist' cohort of staff who can be called upon in the event of a further outbreak.

Minimising influenza transmission and its impact through optimising the UK influenza vaccine strategy

33. Planning for the Influenza vaccination programme is underway with projections of double the level of demand in previous years due to a combination of extended at risk cohorts and expectations of higher levels of uptake. Current assumptions are for 500,000 people across NHSGGC. Additional planning is also required to prepare in the event of a COVID-19 vaccine becoming available. This would extend the duration of vaccination from 10 weeks to as much as 4 -5 months.

34. Capacity in primary care requires further consideration as infection control requirements will significantly reduce the traditional levels of flow. Different arrangements based on high volume community immunisation centres supported by primary care are being explored.

Supporting staff numbers through workforce management to cover sickness, post-contact isolation and necessary time off

35. The pandemic period had a considerable and varied impact on our staff, differing from those dealing directly with the patient demand to those who found themselves locked down in their own homes, shielding or adjusting new ways of remote working.

36. Our remobilisation plan describes the range of measures being employed to respond to the pressures staff experienced, the impact of absence and return to work. As we work through these, consideration will be given to what impact this will have on our base establishment as we move into the winter, with its recurrent seasonal pressures. The priorities being to support our base establishment and to ensure additional workforce in critical areas.

37. This year's Festive Public holidays adjoin the weekends creating a 4 day slow down on each week. Our staffing rotas will be planned with this in mind to mitigate any impact and will be in place by October 2020.

38. Staff wellbeing initiatives in place will continue. A Mental Health and Wellbeing Action Plan has been developed and will be provided to support staff over the next 18 months. Further detail to be shared once support programmes are introduced. Examples of initiatives in place: health and social care workers across NHSGGC now have access to mental health support 24/7 through a new national helpline; acute and community psychological teams will continue to run in addition to the

above support; R&R Hubs have been established for staff breaks from the hospital environment; occupational health team continue to provide counselling and clinical support.

39. Planning for the NHSGGC's Staff Flu Vaccination Programme is underway, it will be predicated on a peer delivery approach recognising that COVID-19 infection control make mass staff drop-in clinics inappropriate. Last year, an online registration system for staff and peers was introduced which enabled improved monitoring and reporting supporting managers with local Workforce Dashboards. Uptake will be monitored on a daily basis with regular reports provided to key stakeholders to inform any reactive measures necessary. Peer Immunisation will be mandated this year for all areas given the traditional amass clinics will not be possible due to physical distancing.

40. The Board's flu vaccination programme will also take into account Social Care staff and Care Home staff.

41. From December through to March, demand on service is matched by increased staffing in critical parts of the system. Additional capacity is augmented at critical times to mitigate backlogs and improve flow particularly around early evenings and weekends:

- ED and Assessment Units to ensure sufficient senior clinical decision makers are available at peak times during early evenings and weekends
- Inpatient Consultant capacity to deliver additional ward rounds at weekends
- AHP capacity to expedite assessment, treatment and discharge planning
- Dedicated boarding teams, to ensure continuity of care and specialist input for patients who cannot be admitted to the appropriate speciality ward
- Extended Pharmacy hours into early evening and weekends
- Additional diagnostic support
- Home care staff
- Equipment provision
- Community discharge teams in evenings/weekends

Business Continuity & Escalation Plans

Business continuity and escalation plans will be tested with partners during the development phase to ensure these are robust and take account of all relevant impacts. The NHS Board has initiated a review of the planning for COVID-19.

13. Appendix 2: Remobilisation Data

Template 1

Copy of Template 1.xlsx

	Month ending 31/08/2020	Quarter ending 30/09/2020	Quarter ending 31/12/2020	Quarter ending 31/03/2021
TTG Inpatient and Day Case Activity (Definitions as per waiting times data mart)	4,344	12,939	15,794	14,841
New OP Referrals Received (Definitions as per waiting times data mart)	16, 622	64,145	100,107	94,413
New OP Activity - (including Virtual - telephone, NHS Near Me,...) (Definitions as per waiting times data mart)	11,264	32,862	52,176	54,028
Elective colonoscopy activity (Definitions as per Diagnostic Monthly Management Information)	588	1,487	2,066	2,324
Elective lower endoscopy activity (Definitions as per Diagnostic Monthly Management Information)	148	356	577	587
Elective upper endoscopy activity (Definitions as per Diagnostic Monthly Management Information)	369	902	1,089	1,878

Elective cystoscopy activity (Definitions as per Diagnostic Monthly Management Information)	333	827	1,299	1,498
A&E Attendances (Definitions as per Scottish Government Unscheduled Care Datamart)	22,176	66,815	66,933	64,252
Number of A&E 4-hour breaches (Definitions as per Scottish Government Unscheduled Care Datamart)	1,109	3,341	3,347	3,212
Emergency Admissions (Definitions as per Scottish Government Unscheduled Care Datamart)	10,293	31,644	42,147	38,696
Admissions via A&E (Definitions as per Scottish Government Unscheduled Care Datamart)	7,407	22,197	28,908	25,709
Delayed Discharges (Total Delayed Discharges of Any Reason or Duration, per the Definition for Published Statistics)	180	176	172	167
Urgent Suspicion of Cancer - Referrals Received (SG Management Information)	3001	8638	11815	12029
31 Day Cancer - First Treatment Patients Treated (Definitions as per published statistics)	410	1275	1569	1809
CAMHS - First Treatment Patients Treated (Definitions as per published statistics)	420	1260	1320	1487

Psychological Therapies - First Treatment Patients Treated (Definitions as per published statistics)	1000	3175	3750	4050

Template 2

Copy of Template 2.xlsx

		Month ending 31/08/2020	Quarter ending 30/09/2020	Quarter ending 31/12/2020	Quarter ending 31/03/2021
Elective colonoscopy activity (Definitions as per Diagnostic Monthly Management Information)	urgent suspected cancer	156	394	436	490
	urgent	226	573	633	712
	routine	206	520	997	1122
Elective lower endoscopy activity (Definitions as per Diagnostic Monthly Management Information)	urgent suspected cancer	10	25	40	41
	urgent	49	117	190	193
	routine	89	214	347	353
Elective upper endoscopy activity (Definitions as per Diagnostic Monthly Management Information)	urgent suspected cancer	165	372	612	684
	urgent	279	627	1031	1153
	routine	415	932	1533	1714
Elective cystoscopy activity (Definitions as per Diagnostic Monthly Management Information)	urgent suspected cancer	39	96	151	174
	urgent	66	163	256	295
	routine	229	568	892	1029

Elective MRI activity (Definitions as per Diagnostic Monthly Management Information)	urgent suspected cancer	322	1074	1194	1194
	urgent	178	594	663	663
	routine	3077	10257	11397	11397
Elective CT activity (Definitions as per Diagnostic Monthly Management Information)	urgent suspected cancer	594	1983	2205	2205
	urgent	818	2727	3030	3030
	routine	2305	7686	8541	8541
Elective non-obstetric ultrasound activity (Definitions as per Diagnostic Monthly Management Information)	urgent suspected cancer	411	1371	1524	1524
	urgent	176	588	654	654
	routine	5291	17637	19599	19599
Elective barium studies activity (Definitions as per Diagnostic Monthly Management Information)	urgent suspected cancer	1	6	9	9
	urgent	0	0	0	0
	routine	2	9	12	12

New Outpatient (12 Week Standard) Activity Projections		Month ending 31/08/2020	Quarter ending 30/09/2020	Quarter ending 31/12/2020	Quarter ending 31/03/2021
All Specialties	Urgent	5570	16074	17101	15866
	Routine	5694	16788	35075	38162
Anaesthetics	Urgent	n/a	n/a	n/a	n/a
	Routine	n/a	n/a	n/a	n/a
Cardiology	Urgent	289	802	795	744
	Routine	258	646	1691	1878
Dermatology	Urgent	835	2555	2760	2248
	Routine	402	987	3552	4007
Diabetes/Endo.	Urgent	28	90	109	141
	Routine	207	685	1057	1177
ENT	Urgent	635	1514	1552	1298
	Routine	273	1021	2398	2508
Gastroenterology	Urgent	174	548	592	527
	Routine	141	462	810	1026

General Medicine	Urgent	18	37	37	29
	Routine	51	106	256	318
General Surgery (inc. Vascular)	Urgent	783	2389	2618	2410
	Routine	393	1751	3346	3728
Gynaecology	Urgent	453	1417	1503	1501
	Routine	406	981	2456	2524
Neurology	Urgent	148	483	656	713
	Routine	189	741	1094	1288
Neurosurgery	Urgent	25	103	134	113
	Routine	59	315	275	359
Ophthalmology	Urgent	461	1335	1399	1304
	Routine	927	2509	4701	5113
Oral & Maxillofacial Surgery	Urgent	43	64	11	9
	Routine	75	272	436	491
Oral Surgery	Urgent	36	114	98	91
	Routine	120	210	647	625
Orthodontics	Urgent	0	0	0	0
	Routine	37	71	202	170
Other	Urgent	744	2160	2265	2101
	Routine	761	2256	4645	5054
Pain Management	Urgent	9	33	17	16
	Routine	95	166	479	380
Plastic Surgery	Urgent	35	104	113	203
	Routine	150	466	597	791
Respiratory Medicine	Urgent	268	790	865	859
	Routine	189	424	1166	1405
Restorative Dentistry	Urgent	0	0	0	0
	Routine	155	322	597	593
Rheumatology	Urgent	195	492	542	505
	Routine	75	195	678	693
Trauma & Orthopaedics	Urgent	112	263	241	291
	Routine	593	1571	2886	2859
Urology	Urgent	279	781	794	763
	Routine	139	630	1107	1174

TTG Activity Projections		Month ending 31/08/2020	Quarter ending 30/09/2020	Quarter ending 31/12/2020	Quarter ending 31/03/2021
All Specialties	Urgent	1531	4465	4612	4367
	Routine	2814	8474	11181	10474
ENT	Urgent	118	312	321	311
	Routine	133	331	559	571
Gastroenterology	Urgent	3	6	11	7
	Routine	153	621	624	595

General Surgery (inc. Vascular)	Urgent	170	492	532	518
	Routine	277	1037	1162	1098
Gynaecology	Urgent	109	374	463	378
	Routine	239	609	865	881
Neurology	Urgent	2	11	7	2
	Routine	19	57	51	50
Ophthalmology	Urgent	134	388	395	338
	Routine	393	1067	1606	1591
Oral & Maxillofacial Surgery	Urgent	85	195	161	154
	Routine	0	0	47	58
Oral Surgery	Urgent	7	18	14	4
	Routine	13	14	35	43
Orthodontics	Urgent	0	0	0	0
	Routine	0	0	0	0
Plastic Surgery	Urgent	144	476	458	422
	Routine	77	211	347	268
Rheumatology	Urgent	2	4	2	2
	Routine	88	276	324	333
Trauma & Orthopaedics	Urgent	161	384	410	355
	Routine	398	1055	1479	1201
Urology	Urgent	134	415	435	518
	Routine	178	559	679	526
OTHER	Urgent	462	1390	1403	1358
	Routine	849	2637	3402	3258

14. Appendix 3: West of Scotland Regional Working Discussion Document

Context

The challenge of COVID-19 pandemic is and will continue to pose a threat to the NHS over the coming weeks and months of 2020 and is likely to remain through 2021. As such the NHS will continue to work in an emergency planning environment focused on stratifying care to avoid loss of life and minimise harm to patients who have urgent and ongoing health care needs as well as to find a way to undertake and increase the level of routine care.

In planning for this, the West of Scotland Boards under the Mutual Aid agreement have considered and agreed a regional approach to a number of areas outlined below. The regional response is in line with the planning assumptions set out by Scottish Government to optimise what we can do collectively in these challenging times.

Unscheduled Care

Building on the effectiveness of the COVID-19 response and the expectations of the Cabinet Secretary of progress in implementing a consistent national approach to urgent care before winter (October 2020) the Boards within the West of Scotland continue to build on the collective position set out the in phase 2 mobilisation plans where the most important priority identified by the Medical and Nurse Directors going forward was to move from a model of unplanned attendance or assessment to one based on a planned appointed clinical system This requires the adoption of new models to support the urgent and emergency care response across the wider healthcare system encouraging joined up pathways and models of response to unscheduled care involving NHS24, SAS, GP In-hours, GP Out of Hours and Emergency Departments.

In line with the work being undertaken nationally, this is about the creation of a national 24/7 pathway with clear access to urgent care through 111, providing consistent triage then linked to local hubs for further clinical consultation and flow management locally if required. The Board plans set out the information in the relevant sections which will see the creation of MDTs to support the local hubs, with the hubs/ MDT providing virtual consultation to determine if face to face assessment is required and, if so, to make onward appointments to the hub or to ED or to direct to another service. The initial focus is to provide a pathway into urgent care for those who currently self-present at ED (typically, 50-60% attendances), the ultimate goal is to develop a model across all urgent care that is 24/7, i.e. ED, MIU, GPs, SAS and to have made significant steps forward in implementing that by October.

The potential safety gains of a more controlled approach to unscheduled care attendance to any healthcare setting will be significant by avoiding overcrowding and unnecessary face to face contact and may play an important factor in mitigating or reducing winter pressures generally and any additional COVID-19 pressures that emerge in the future.

Cancer and Scheduled Care

During the first wave of the COVID-19 Pandemic specialty specific groups reviewed their pathways and altered their approaches to treatment to reflect this new and additional risk to minimise the risk of preventable harm and optimise outcomes, for patients requiring cancer

treatment including surgery, systemic anti-cancer therapies or radiotherapy. Much of this work was facilitated through the regional Managed Clinical Network and Multi-disciplinary teams.

In this next phase of mobilisation we will continue to follow the guidance set out in the *'Framework for Recovery of Cancer Surgery'* formulated by the Scottish Government COVID-19 Cancer Treatment Response Group.

It is recognised as surgery services increasingly enter into the recovery phase in the coming weeks and months there will be competing demands from various surgical specialties to gain access to a limited surgery resource. Each of the Boards within the West of Scotland have developed local clinical prioritisation groups to ensure fair and reasonable access to a limited surgery resource in terms of both hospital beds and elective green-site theatre capacity.

Whilst there is an expectation that all boards will upscale their elective cancer surgery capacity in the coming months to address the backlog there needs to be a recognition that there is a reduction in theatre capacity across the Boards and the region which will require cooperative working arrangements to be put in place to ensure patients with the greatest priority are treated and patients in Board areas seeing a higher level of COVID-19 admissions are not unfairly disadvantaged.

Setting the Collective Response

In planning for the next 6-12 months, recognising the above and uncertainty around COVID-19, we have considered five possible scenarios to determine our collective responses and actions. This work primarily relates to acute care and hospital services.

Our aim is to gradually and safely, increase the level of services provided for our population, building on our mutual aid agreement to provide the best level of service across the region whilst continuing to ensure outcomes from other life limiting or life threatening conditions is not impacted. In doing this we will also work with our partner agencies particularly SAS, NHS 24 and the NHSGJNH and NHS Louisa Jordan (NHSLJ) where required.

The scenarios identified are as follows:

1) The Rate remains below 1 and hospital and specifically critical care admissions remain on the current trajectory allowing us to steadily increase the level and range of services we offer.

2) Small localised outbreaks in areas within the region that requires the Board to have a focused response to testing, tracing and isolating with localised lock downs which may require hospitals services to be temporarily reduced or suspended and mutual aid is required across the boards to support and minimise disruption to the care of urgent patients.

3) Several areas show significant spikes that require alterations to patient flows and support from services from neighbouring boards to reduce disruption to access appropriate clinical care for urgent and planned patient care.

4) The rate increases and we face a similar situation to the first wave and we require to implement mutual aid across the system in relation to critical care, acute emergency flows at the same time maintaining priority 1 treatments/ interventions.

5) The second wave is greater than the first and there is full implementation of the critical care network plans and NHS Louisa Jordan is required to provide the support envisaged at the time of initial commissioning.

In considering these different scenarios we recognise in the period August 2020 to March 2021 these may be compounded by the increased unscheduled care demand routinely experienced in all hospitals in the winter period particularly if there is a combination of a significant flu outbreak, and low uptake of flu immunisation amongst higher risk groups.

Recognising the uncertainty the NHS is facing and in response to the above positions, under our commitment to supporting mutual aid across the region, a number of cross board approaches have been developed. This has involved working collectively to set out the direction for unscheduled and cancer and scheduled care across the region supported by the establishment of a number of networks within the region, which are outlined in this paper. Supporting papers, setting out the detail of the working arrangements, are available. Within these documents the escalation approach is described and the expectation of support from NHS GJNH and from NHS LJ.

West of Scotland Acute Care Network

The Acute Care Network was established to allow us to plan collectively and coordinate action within acute services across the region during the COVID-19 pandemic when required. This group is linked to the West of Scotland Critical Care Network, taking cognisance of the changing position within critical care across hospitals and boards which was crucial during the first wave of the pandemic. Both of these networks are supported by the Regional Planning Team.

This network is set up with the remit to support and co-ordinate the collective emergency response to COVID-19 and to pressures in acute services when required. Weekly calls have been established with the Acute Directors or their nominated representatives to support closer working and more joined up approaches as well as to plan recovery and remobilisation together and share learning in these challenging times.

The frequency of meeting is determined by the level of escalation based on the level of COVID-19 admissions to the hospital or where acute emergency care services are under duress. The group is supported in its decision making through the collation of essential information agreed by the Acute Directors in relation to their Boards to allow a shared understanding of the position across the region to support, where possible, ensuring patients get access to the most appropriate level of care. This is based on the premise that we will have the ability to direct people to another site like diverting GP calls to different site or transfer of patients between sites to use the available capacity to greatest effect.

The call will cover an agreed set of questions / data collection and will use the information currently required nationally to collate a regional picture for consideration thus avoiding duplication of effort. This includes the information from the daily update position including

the assessment of status, by site, on ability to maintain services over next 24-72 hours across key questions to assess ability to:

- maintain business critical services
- maintain emergency care pathway
- support major incident response
- have sufficient workforce

This group will also identify when pressures are mounting that will trigger the need for national action and the implementation of the plans for NHS LJ in line with the position issued nationally during the first wave.

West of Scotland Critical Care Network

The Boards and Hospitals in the West of Scotland established a West of Scotland Critical Care Network early in the first wave of COVID-19 pandemic. This included establishing a daily critical care network teleconference call covering an agreed set of questions. The call allowed us to coordinate critical care services across the region during that period. This call is attended by an Intensive Care Consultant or Senior Charge Nurse from every unit which provides Intensive Care who is responsible for providing the essential regional activity information to allow an understanding of the position across the region to be quickly gathered to help ensure where possible patients get access to the most appropriate level of care. This network works on the premise we have the ability to transfer patients between sites to use the available capacity to greatest effect. Part of the West of Scotland Critical Care Network is providing a transfer team to support this when required. Going forward the role of NHS LJ in contributing ICU expansion, if any, will need to be clarified.

The daily activity monitoring provides a regional overview of critical care network activity and capacity on a daily basis and helps identify rapidly where Intensive Care Units (ICUs) may require support. This is also a platform for sharing issues encountered, successes and challenges for shared learning purposes.

When a strong regional response is required calls are scheduled for 1.30pm daily unless otherwise agreed by the co-chairs in discussion with West of Scotland Board representatives. If occupancy in the 12 general ICUs is less than 140% of baseline and 80 or more staffed beds are available on a Friday then weekend calls are not be undertaken. However the information is still collated and shared across the region. The network chairs review the information and contact ICUs if there is a significant deterioration in capacity.

If less than 50 patients with COVID-19 are in ITUs, occupancy is less than 90% of baseline and more than 50 staffed beds are available then the weekly calls are suspended. Data returns continue to be collated, with the chairs reviewing the information daily and contacting ITUs if there is a significant deterioration in capacity.

Calls are suspended when the activity levels are within the baseline however the group continues to meet as required to share learning and consider the collated position and trend in activity. The daily call will recommence if it becomes apparent that the amount of COVID-19 activity indicates an impending spikes or a second or subsequent surge, agreed with Medical Directors as 140% of baseline as the trigger point for the daily calls. The network reports to the West of Scotland Medical Directors in terms of governance.

Regional Cancer Prioritisation, Scheduled Care and Diagnostics

Building on the work undertaken in the first wave by the specialty specific groups through the MCNs and MDTs to review their approaches to treatment and prioritisation to reflect this new and additional risk the local clinical prioritisation groups in Boards will link with the Regional Clinical Prioritisation Group which has been established. This involves both senior clinical leaders and senior manager involved in managing cancer and access programmes in each Board across the region.

An overall governance and performance approach is central to implementation of the Surgical Prioritisation Framework within the West of Scotland. The development of this regional group will support the principles and aims of the Surgical Prioritisation Framework through the development of a planned approach to meet the needs of patients treated within the West of Scotland and ensure timely access to surgery.

The purpose of this group is to monitor performance against the approved framework and plan appropriate regional working where a risk has been determined. Boards will need to work together to collectively and collegiately plan access to surgery and this may require transfer of patients or staff (or both) to adjacent and or co-located Health Boards within the network.

Through the West of Scotland Surgical Prioritisation Group the aim is for patients to be treated and listed for surgery in order of clinical priority in the same way across the region to ensure equitability; working together to ensure patients are offered the earliest available appointment. This group will also consider how to maintain services and address the backlogs in the event of increased COVID-19 activity.

NHS GJNH will be an important participant in this group to ensure the capacity available at the GJNH can be maximised to support the treatment of patients within the region where surgery capacity does not allow this within the board of residence.

It is recognised that this is a challenging task, and there may be significant need for cross HB working and/or national support and rescue of some cancer services on a temporary basis. In doing this it will be important to use capacity most suitable to meet the clinical need; recognising the importance of the wider clinical team in supporting patient care post-operatively to optimise patient outcomes

In terms of the wider planned care requirements to support outpatients and diagnostic investigation of patients the West of Scotland Boards are also considering the opportunities the NHSLJ may offer when not required to provide inpatient care to support the response to COVID-19. Some test of change have been carried out for orthopaedics and plastic surgery and the review of the learning from these will be considered to explore the wider use of this capacity to support outpatient activity as well as diagnostic capacity in the coming months.

Part of the work being undertaken across the region is reviewing the capacity and demand for diagnostic tests to support patient management. This work will be used to support the Clinical Prioritisation Groups locally and regionally and inform the dialogue with our primary care colleagues to use the available capacity to best effect.

Summary of Potential Mutual Aid

Table 1 summarising the levels of potential support at each stage

Responses	Scenario 1	Scenario 2	Scenario 3	Scenario 4	Scenario 5
Acute Care Network	Planning and Monitoring Sharing Learning	Planning and Monitoring Sharing Learning	Monitoring need for escalation and supporting care as required	Escalation plans being implemented Supporting care as required	Full escalation and support across the system
Critical Care Network	Planning and Monitoring Sharing Learning	Planning and Monitoring Sharing Learning	Monitoring need for escalation and supporting care as required	Escalation plans being implemented Supporting care as required	Full escalation and support across the system
Cancer and scheduled care	Developing capacity plans and aligning demand based on clinical priority	Monitoring and supporting priority patients treatment where required	Monitoring and supporting priority treatment where required/ review reducing elective surgery activity	Supporting priority treatment only	Supporting emergency treatment only
Diagnostics	Developing capacity plans and aligning demand based on clinical priority	Monitoring and supporting priority patients treatment where required	Monitoring and supporting priority treatment where required/ review reducing elective diagnostic activity	Supporting priority diagnostics only	Supporting emergency diagnostics only

Mitigating Risks and Rate Limiting Factors

Recognising we are managing a situation where COVID-19 is endemic in the population and is likely to remain for the foreseeable future it means that we may face a number of challenges across the services where parts of services may be temporarily reduced or suspended because of staff also getting infected. This requires us to have the agility and

flexibility to support care for the most critical patients at any time and this may require a greater level of cross board working than we have required to date.

Also recognising the levels of demand for services particularly during the winter period could prove challenging based on past experience it is important that we recognise what we require to do to sustain capacity to respond to rapidly changing numbers of COVID-19 patients and emergency demand.

Key to this are:

- Use the data to provide an Early Warning System to guide our decision and levels of escalation linking also with SAS and NHS 24 to use the data they are also gathering to ensure we can monitor the position and identify patterns that are causing concern to trigger our collective response

- Shared understanding of the capacity we have to support care recognising the need to keep capacity to support an ongoing level of COVID-19 patients both in terms of critical care capacity and respiratory care. This is particularly important as we build our surgical capacity to ensure we have the agility and flexibility to adjust quickly to changing situations minimising the level of disruption this could cause.

- Having a clear strategy for testing and a framework that sets out the different levels of testing and response at different levels of escalation.

  Further work is planned to explore mutual aid to support resilience across the region recognising the different levels of risk in the scenarios outlined above for our Test and Protect Services in relation to demand and capacity, particularly recognising the similarities of some of the symptoms between COVID-19 and flu. Consideration will be given to a developing a framework of response to manage the different risks that might arise especially if we return to scenario 4 or escalate to scenario 5.

- Ongoing education and training of staff will be required to maintain and enhance the wider team development, working to cope with the increase in clinical activity in the critical care areas, and beyond (e.g. early CPAP in ward areas). Consideration of critical care nursing skills becoming more generic within the workforce would also be beneficial.

- Being clear about the PPE requirement and supplies availability to support acute/ critical care as well as elective activity especially as we increase our endoscopy capacity where there is a heavy requirement for PPE- visors and gowns.

- Recognising the importance of Pharmacy and Medical Supplies to all aspect of patient care covered in this paper it is important that consideration is given to how the Pharmacy teams work together to support the necessary input to patient care, particularly in areas where there is a small cohort with specialist knowledge and skills such as for critical care.

  To prepare for any further potential surges in COVID-19 activity across the region medicine supplies require to be coordinated centrally as Boards will reintroduce services at varying levels. This needs to consider NHS Boards reporting medicine supply levels and potential related planned activity to a central point. A list of the most commonly used drugs and level of stockpile agreed in terms of quantity, location and access to ensure if scenario 5 comes about there is sufficient stock around to meet demand.

Clearly defining future mutual aid to support cross board working in managing the supplies would be helpful this should consider agreement that medicine supplies are co-ordinated across Scotland and supply follows the patient need.

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Glossary

ACRT	Active Clinical Referral Triage
AOFMS	Academy of Medical Sciences
ASH	Action on Smoking & Health
ANP	Advance Nurse Practitioner
AGP	Aerosol Generating Procedure
AHP	Allied Health Professional
ACH	Ambulatory Care Hospital
ACP	Anticipatory Care Planning
AU	Assessment Units
ACS	Assisted conception services
R0	Basic Reproduction Number
BME	Black and Minority Ethnic
BBV	Blood Borne Virus
BMJ	British Journal of Medicine
BI	Business Intelligence
COPD	Chronic Obstructive Pulmonary Disease
CACs	Community Assessment Centres
DHI	Digital Health & Care Institute
ENT	Ear, Nose & Throat
EQuIP	Effective and Quality Interventions and Pathways
EHCR	Electronic Health & Care Record
ED	Emergency Department
EQIA	Equalities Impact Assessment
EU	European Union
FFP	Filtering Face Piece
FAQ	Frequently Asked Questions
GP	General Practitioner
GRI	Glasgow Royal Infirmary
GJNH	Golden Jubilee National Hospital
GGC	Greater Glasgow & Clyde
HSCP	Health & Social Care Partnership
HDU	High Dependency Unit
HEPMA	Hospital Electronic Prescribing and Medicines Administration
ICU	Intensive Care Unit
MCN	Managed Clinical Network
MH	Mental Health
MPP	Modernising Patient Pathways
MDT	Multi-Disciplinary Team
NSS	National Services Scotland
NESI	Needle Exchange Survey Initiative
NDS	NES Digital Scotland
vCreate	New video technology system
NES	NHS Education for Scotland
ORTHO	Orthopaedics
OBC	Outline Business Case
PPE	Personal Protective Equipment

PHS	Public Health Scotland
qFIT	Quantitative Faecal Immunochemical Test
QEUH	Queen Elizabeth University Hospital
R&I	Research & Innovation
RAH	Royal Alexandra Hospital
STAC	Scientific and Technical Advisory Committee
SAC	Scottish Access Collaborative
SAS	Scottish Ambulance Service
SCI	Scottish Care Information
SSTS	Scottish Standard time System
SATA	Specialist Assessment and Treatment Centre
UKG	UK Government
USC	Unscheduled Care
USOC	Urgent Suspicions of Cancer
VOL	Vale of Leven
VACH	Victoria Ambulatory Care Hospital
WLI	Waiting List Initiative
WTE	Whole Time Equivalent